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Deposited in DRO:

20 May 2011

Version of attached file:

Published Version

Peer-review status of attached file:

Peer-reviewed

Citation for published item:

Wistow, R. and Barnes, D. (2009) 'A profile of child and adolescent mental health services in England 2007/8.', Technical Report. Durham University, School of Applied Social Sciences, Durham .

Further information on publisher's website:

<http://www.childrensmapping.org.uk/>

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A profile of child and adolescent mental health services in England 2007/8

findings from children's services mapping

Richard Wistow and Di Barnes



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Chapter 1.

Key Messages



Introduction

- 1.1 This 'atlas' reports the findings of the 2007/8 CAMHS mapping exercise. The report provides a focus on CAMHS and should be read alongside *A profile of child health, child and adolescent mental health and maternity services in England 2007/8* that reports the full mapping exercise and covers the 11 standards of the children's national service framework.
- 1.2 Response rates to the data collection remain high. However, CAMHS mapping is a voluntary exercise, therefore participation rates vary year-on-year and the data should be read with caution (see Appendix 1 for 2006 and 2007 completion rates).

Spend and Budget

- 1.3 Actual spend on CAMHS in the financial year 2006/7 exceeded £523M. This was an increase of 14% on the 2005/6 spend of £461M, a more substantial growth than the 7% increase recorded between 2004/5 and 2005/6. Between 2003/4, when the CAMHS mapping data became reliableⁱ, and 2006/7 the overall growth in spend on CAMHS has been in the order of 62%.
- 1.4 In 2006/7:
 - Actual spend (£523M) exceeded the predicted spend (£507M) by 3% and the predicted budget for 2007/8 indicated a further 8% rise in expenditure to £565M
 - CAMHS spend by PCTs was £419M and local authority reported spend was £103M (20%) but as only 77% of local authorities submitted finance data this figure is an underestimate.
 - CAMHS PCT and local authority spend per child of the population aged 0 to 17 was £47.32 (inter-quartile range of PCT spend per child of £26.26 to £48.43), an increase from £41.71 per child in 2005/6 (PCT inter-quartile range £26.05 to £45.36).

Workforce

- 1.5 The total workforce reported for 2007 was 10,375 wte, an increase of 579 wte (6%) on the previous year. The total increase since 2003 when the mapping data became reliable was in the order of 34%.
- 1.6 Looking at local teams that serve a defined local population there were an average of 94 wte CAMHS staff per 100k aged 0 to 17 years in 2007, an increase from 88 wte on 2006, 89 wte in 2005 and 80 wte in 2004.
- 1.7 Nurses made up 22% of the CAMHS workforce in 2007, administrators 15%, clinical psychologists 12% and doctors 11%. Primary mental health workers and social workers each made up 6% of the workforce.

ⁱ The mapping was piloted in 2002 and carried out nationally for the first time in 2002/3. The reasons why 2003/4 is seen as a benchmark in the reliability of CAMHS data as a whole are: 1) 2003/4 marks a shift from development to establishment of the collection method and classifications; 2) the processes of mapping had become more familiar and embedded for those responsible for completing the mapping.

Comprehensive CAMHS provision

- 1.8 A total of 1,047 specialist CAMHS teams were reported in 2007, 1% less than 1,055 reported in 2006. This was the first year that a fall in the number of CAMHS teams had been reported since the first mapping exercise in 2003.
- 1.9 In NHS tier 4 provision there has been a continued fall in the number of services provided. In 2007 there were 621 commissioned inpatient beds, 368 day places, 724 intensive home support places and 86 intensive foster care places reported.
- 1.10 The provision of alternatives to inpatient care by CAMHS tier 2/3 teams reduced slightly from 458 (48%) teams in 2006 to 374 (40%) teams in 2007. Early intervention services were provided by 210 teams in 2007, up from 187 the previous year.

CAMHS proxies

- 1.11 Very good progress has been made on the provision of CAMHS on-call services with only 2% of NHS providers reporting no services, protocols or plans in place. A further 4% of NHS providers had plans and protocols but no services in place, 34% had some on-call services in place with some still to be developed and 61% had a fully comprehensive on-call service available. 56% of NHS on-call services were staffed by CAMHS professionals. Next working day appointments for children and young people needing emergency care or assessment were offered in 76% of the NHS providers where fully comprehensive services were available and in 21% of trusts where some services were in place. Similar progress was reported by local authorities with 65% reporting fully implemented on-call services available throughout their area, 33% reporting having plans and protocols in place and partially implemented services and only 1% with no services in place.
- 1.12 A total of 90% of NHS CAMHS provided age appropriate care for young people aged 16 and 17 in 2007 with 49% providing fully comprehensive age appropriate CAMHS and 41% provide some services, with other services still to be developed. 2% of NHS trusts had plans and protocols in place, but were yet to implement them, while 7% had no services, plans or protocols for age appropriate 16/17 CAMHS provision. 52% of local authorities reported fully comprehensive provision (up from 11% the previous year) and a further 45% had plans and protocols in place and some services. 3% were yet to develop any services.
- 1.13 87% of NHS CAMHS reported specialist learning disability provision, 33% with a fully comprehensive service and 54% with some services in place but with others still to be developed. 3% of trusts had plans and protocols but no learning disability services and 8% of NHS providers had no services, plans or protocols. 39% of local authorities had fully comprehensive provision for learning disabled children and young people with mental health problems and 57% had plans and procedures in place but were yet to ensure provision throughout the LA area and 3% reported no specialist learning disability and mental health provision.
- 1.14 Local authorities reported improved arrangements for, and provision of, services for children and young people with complex needs. Over half of the local authorities (53%) reported having fully operational partnership working throughout their area, 39% had plans and procedures in place and some access arrangements, 7% had plans and procedures but their access arrangements were not operating and 1% had no plans or services.

Activity

1.15 A total of 109,131 active CAMHS cases were recorded in the 2007 sample period and 50,596 consultations, giving a total of 159,727 cases.

- The number of new cases seen within the sample period was 29,518 in 2007. This marked an overall growth of 80% in new cases seen since 2003 and a 2% increase on 2006.
- The majority of new cases first seen in the sample period had waited 4 weeks or less (53%), 35% had waited 1 to 3 months, 8% waited 3 to 6 months and 4% waited longer than 6 months.
- The number of cases waiting at the end of the sample period (1st to 30th November) has fallen annually since 2004. It fell by 5% between 2006 and 2007 to 22,592 cases. Increased activity and the reduction in waiting times was reflected in the fact that the number of cases waiting 4 weeks or less continued to rise whilst the number of cases waiting over 4 weeks fell across all categories.

Chapter 2.

Introduction



Overview

- 2.1 This report summarises the findings of the sixth annual child and adolescent mental health service (CAMHS) mapping exercise that was carried out between 1st November 2007 and 28th February 2008. Although CAMHS mapping was merged with the child health and maternity services mapping exercise in 2006, this report focuses on information about specialist CAMHS service provision and expenditure only. This includes services defined as tiers 2-4 in the four-tier CAMHS framework developed in *Together we stand*¹ and expanded upon in *Children in Mind*² (Box 1 and Appendix 2).

Box 1: The four-tiered CAMHS framework³

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinicians). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multidisciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

- 2.2 CAMHS mapping was developed in 2002, since when it has been completed each year. The data reported has been used to support the measurement of performance and to help drive forward improvements in CAMHS investment, staffing and activity. Over the six years of CAMHS mapping, annual reports have been able to report steady growth in specialist CAMHS provision and progress towards the provision of comprehensive CAMHS throughout the country. However, uneven provision has been reported, reflecting the findings of the 2008 CAMHS review⁴. This independent review found that CAMH services were not as comprehensive or as good as they could be and inequalities in access to services remained. They made 20 recommendations for improvements and progress in achieving these will be tracked by subsequent mapping exercises.
- 2.3 In 2005, the mapping system was extended to cover dedicated child health and maternity services and in 2007 the first joint report of the mapping exercise was published which was structured around the 11 standards of the National Service Framework for Children, Young People and Maternity Services⁵ (referred to below as the children's NSF). The second joint report has been published in February 2009 and should be read alongside this publication.
- 2.4 The report summarises the findings at a national level with some references to regions but all data can be interrogated at the level of Strategic Health Authority (SHA), NHS organisation, and individual service at: www.childrensmapping.org.uk/reports.

Purpose of mapping

- 2.5 Child health, CAMHS and maternity service mapping is an online data collection and reporting system that creates an annual snapshot of national service provision and investment. As yearly data accumulates, trends are generated that indicate where, and in what direction, change is taking place. This underlines the principle aim of the mapping exercise to contribute to the monitoring of the implementation of the children's NSF and the Every Child Matters (ECM)⁶ agenda. The improvement of the mental health and psychological well-being of children and young people is both a priority for Standard 9 of the NSF and an ECM outcome. CAMHS mapping focuses on services dedicated to this aim.
- 2.6 Other purposes of the child health, CAMHS and maternity services mapping exercise include:
- To support Primary Care Trusts (PCTs) and other partners in developing joint commissioning strategies
 - To support joint service planning, development and provision
 - To assist in the bid for resources
 - To act as a source of data for national, regional and local performance monitoring
 - To provide annual updates for the development and maintenance of local service directories.
- 2.7 In addition CAMHS mapping aims to:
- Act as a source of data for performance measurement and monitoring
 - Assist in the bid for resources for CAMHS development
 - Support local service development and gaps analysis
 - Facilitate local benchmarking.

Mapping process

- 2.8 The 2007/8 CAMHS mapping exercise contained three elements:
1. Service mapping which builds up an inventory of specialist CAMHS teams and is led by NHS trusts, including PCTs that provide CAMHS
 2. Financial mapping which is completed by PCT commissioners who are asked to record their actual spend on specialist CAMHS for the last financial year (April 2006 to March 2007) and their predicted budget for the current year (2007/8)
 3. Local authority mapping which required a parallel finance mapping exercise and information on four performance indicators for Ofsted.
- 2.9 As CAMHS mapping has become well established, CAMHS teams are now on the system and data inputting requires only revisions and updates each year. However, the work involved in data update is considerable as staffing information has to be checked, caseload numbers have to be collected and details of the type of service delivered have to be revised. The success of CAMHS mapping owes a great deal to the thorough way that this data has been submitted each year.
- 2.10 For the child health, CAMHS and maternity service mapping in 2007/8, the key stages in the mapping process were as follows:
- All CAMHS providers and commissioners were required to nominate a lead manager to take responsibility for seeing that the data collection was completed. Mapping leads were responsible for setting up the exercise, structuring it to suit local circumstances and nominating colleagues to assist in completion of the exercise.

- For all teams delivering tier 2-4 CAMHS, details of their provision, function, specialisation, staffing and activity are requested. Some details of the characteristics of the children and young people CAMHS staff worked with are also needed. All data are input online and the website provides reports that can be examined and printed to enable the data to be interrogated.
 - All data had to be entered by 28th February 2008 and signed off as correct by the Chief Executive of the NHS provider trust or local authority Director of Children's Services.
- 2.11 PCT commissioners were required to register on the website and submit data on their CAMHS budget for the last and current financial year, distinguishing how much of the budget was spent with each of their service providers. Local authorities also registered directly on the website and provided financial data on local authority CAMHS budgets and information on their progress in meeting national targets on CAMHS provision. The performance data were sent to Ofsted for use in local authority performance rating in November 2008.

A helpdesk operated throughout the mapping period and could be contacted by phone or email.

Terminology

- 2.12 Definitions of the terms used in the atlas are provided in the relevant chapters but special note should be taken of terms used to describe teams. CAMHS teams are usually described within the tier 1-4 framework. However, in the development of the CAMHS mapping, it was found that the tier system was not enough to denote the structure and function of the teams and so a team type was created to provide a shorthand team descriptor.
- 2.13 The team types that have evolved include: generic teams (both multi and single discipline); targeted teams; dedicated CAMHS worker teams; and tier 4 teams. Broadly, the first three team types equate to tiers 2/3. For tier 2/3 teams, caseload data were collected over a sample month, November. For tier 4 teams, which involve more intense interventions being provided over a longer period, caseload data were collected over a 6-month period, June to November.

Accuracy and completion

- 2.14 Although child health, CAMHS and maternity service mapping is a voluntary exercise, response rates of over 90% were achieved in 2007 giving considerable confidence in the completeness of the data (see Appendix 1). In the exercise there is also a process of signing off that the questionnaires have been completed and checked and so high levels of sign off should indicate greater accuracy in the data submitted. Nevertheless, the information should be read with caution as there are gaps and inconsistencies. Despite this, the exercise provides a valuable national profile of provision and investment, enabling pertinent questions to be raised and issues to be debated.
- 2.15 At a national level the mapping data gives a good indication of levels of service provision, investment and the direction of change. At regional and local levels, gaps and inconsistencies tend to be easier to identify by those with local knowledge. Consequently, the mapping data may raise as many questions as it answers. Paradoxically, this is one of its major strengths as it can stimulate informed debate and help to

develop understanding both of the nature of services provided, and who they are being provided for. Where data stands out as different, this may indicate errors in inputting or missing information that can be corrected next year. Equally there may be reasons for the difference that are helpful to articulate and explore.

- 2.16 Where data needs further investigation, it can be 'drilled into' using the online tables on the mapping website www.childrensmapping.org.uk/reports. By clicking on the hyperlinked names on the left-hand side of all tables, access is given to the original questionnaire completed about each service and the totality of information submitted about that service can be scrutinised.

Using this atlas

- 2.17 The broad structure of previous CAMHS atlases has been adopted for this report but a key change has been the production of a joint 2007/8 child health, CAMHS and maternity service mapping executive summary. This is produced in a separate booklet and only highlights of it are reproduced here. The structure of the atlas is as follows:

Chapter 1: Executive summary. CAMHS highlights

Chapter 2: Introduction. This gives the background to the mapping exercise and an overview of the mapping process and reporting.

Chapter 3: Investment. This provides information on total expenditure on CAMHS and trends in spending.

Chapter 4: Workforce. This looks at trends in the CAMHS workforce.

Chapter 5: Developing comprehensive CAMHS. This chapter sets out the elements of a comprehensive CAMHS highlighting elements of services such as team types, on call, learning disability services and the suitability of services for 16-18 year olds.

Chapter 6: Comprehensive CAMHS: delivery of functions and collection of outcomes. This section examines some of the work undertaken by CAMHS teams and the outcome measures used to evidence their work.

Chapter 7: Caseload. This reports on characteristics of the children and young people who use CAMHS services and waiting times for accessing services..

Completion rates, the CAMHS tier 4 framework and technical aspects of the exercise are explained in the Appendices.

Local access to data

- 2.18 The Durham Mapping Team is continuing to develop the ways it reports mapping data and provides tools for data interrogation. On the mapping website there are national, regional and local reports, a service directory facility and a comparator tool for setting up customised reports. If you have any difficulties using these facilities, or have requests for data that you need, please contact the team.
- 2.19 The website can be found at: www.childrensmapping.org.uk.
The Mapping Team can be contacted at: help@childrensmapping.org.uk.

Chapter 3.

Investment



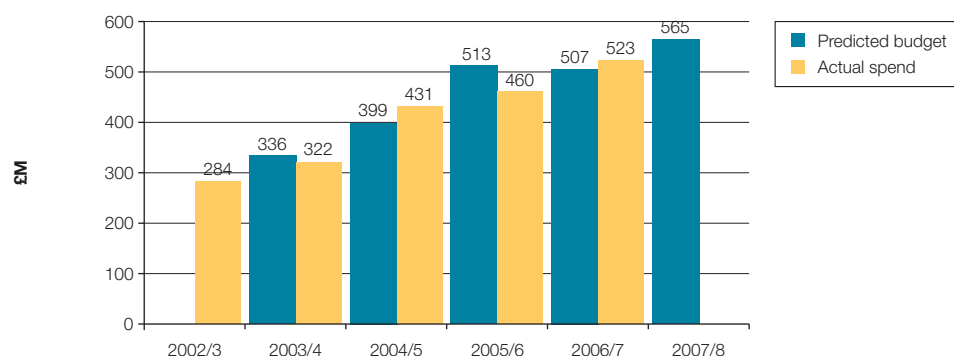
Introduction

- 3.1 This chapter reports the findings of the CAMHS finance mapping that was completed by both PCT and local authority commissioners in 2007/8. This was the fourth year that PCT commissioners had submitted data and the third year that local authorities were asked to complete a separate submission.
- 3.2 A key finding of the mapping is the trend in investment in CAMHS tier 2 to 4 services. It should be noted that this is calculated annually from the data supplied in a single year in order to ensure that reference is being made to the same services in each year of the comparison. Therefore, the 2007/8 mapping exercise collected data on the actual spend for 2006/7 and the predicted budget for 2007/8 – data entry was completed in early 2008 before the end of the financial year.
- 3.3 The chapter presents the following sections:
- Total CAMHS spend
 - PCT and LA share of CAMHS investment
 - Source of funding
 - Spend per child
 - Spend on tier 2/3 and tier 4 teams
 - Individual care
- 3.4 As the finance mapping is complex, requiring identification of investment in CAMHS tier 2 to 4 services by commissioner and providing agency, it is very difficult to confirm the accuracy of the data submitted. However, a number of checks have been built into the mapping exercise that give indications of the completeness of the data returned. The rate of sign off by Chief Executive Officers of PCTs was 95%, up from 87% in 2006. The rate of sign off of local authority investment in CAMHS by the Directors of Children's Services was 76% in 2006 and 77% in 2007. Further confidence in the data was given by the fact that 95% of individual PCT finance spreadsheets and 93% of LA spreadsheets were confirmed complete. The data were also cleaned prior to analysis with checks carried out to identify outliers and errors. All errors that were identified were later corrected by the relevant PCT and LA but as 48% of spreadsheets contained estimated data only, the information reported should be interpreted with caution.
- 3.5 This chapter reports at national and regional levels only. Detailed tables of the data used can be found and downloaded from the CAMHS mapping topic reports at: www.childrensmapping.org.uk/reports.

Total CAMHS spend

- 3.6 Actual spend on CAMHS tiers 2-4 (see Appendix 2) in 2006/7 was £523M. This was an increase of 14% on 2005/6 and much stronger growth than had been seen the previous year when the increase had been only 7%. Between 2003/4, when CAMHS mapping data became reliable, and 2006/7 the overall growth in spend on CAMHS has been in the order of 62% (Fig. 3.1).
- 3.7 Although direct year on year comparisons can be problematic because of changes to the way finance data has been collected, it is interesting to note that only twice has actual expenditure exceeded that predicted. The first time was in 2004/5 when the rise could be attributed to local authorities being invited to map their expenditure on specialist CAMHS. The second time spending exceeded the budget was in 2006/7 when a difference of 3% was recorded between the actual spend of £523M and a predicted budget of £507M. A further increase of 8% has been predicted for 2007/8 which would take annual spending on CAMHS up to £565M.

Fig. 3.1: Budget change 2004/5 and 2005/6 - total tier 2-4 CAMHS budget



- 3.8 When the predicted budget change between 2006/7 and 2007/8 is examined by SHA, the variation ranges from an increase of 23% to an increase of 4% (Table 3.1).

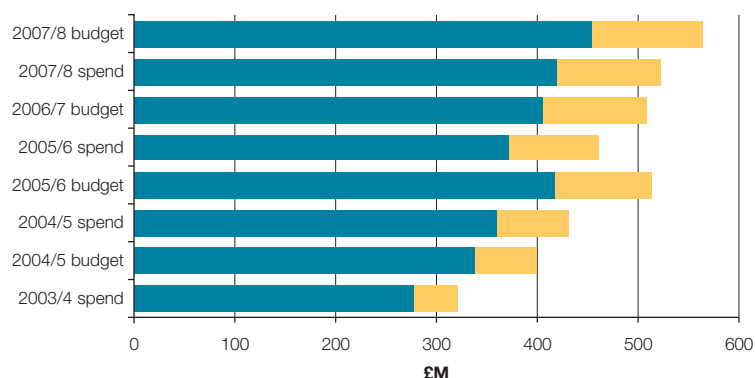
Table 3.1: 2006/7 actual spend and 2007/8 predicted budget by SHA

2007	Total Spend 2006/07 CAMHS £k	Budget 2007/08 CAMHS £k	Budget change (£k)	% change in budget
East Midlands	38,434	39,792	1,358	4%
East of England	54,074	57,037	2,963	6%
London	120,066	124,910	4,845	4%
North East	38,423	41,337	2,915	8%
North West	49,072	53,840	4,768	10%
South Central	34,065	41,955	7,889	23%
South East Coast	38,859	42,568	3,709	10%
South West	39,533	45,559	6,026	15%
West Midlands	44,268	48,211	3,943	9%
Yorkshire & Humber	40,924	43,708	2,785	7%
Not allocated to region	25,058	26,168	1,110	4%
Total	522,775	565,086	42,311	8%

PCT and LA share of CAMHS investment

- 3.9 In 2006/7, CAMHS spend by PCTs was £419M and local authority reported expenditure was £103M (Fig. 3.2). However, as only 77% of local authorities submitted finance data, this was an underestimate. The proportion of the total reported CAMHS budget provided by local authorities has remained around 20% since 2005/6 however the real figure is likely to be closer to 24%.
- 3.10 There has been a reported increase of £48M (13%) in the actual spend of PCTs between 2005/6 and 2006/7, and a reported £141M (51%) increase in PCT spend between 2003/4 and 2006/7. LA reported spend on CAMHS has also increased substantially, from £44M in 2003/4 to £103M in 2006/7, a 134% increase in CAMHS spend.

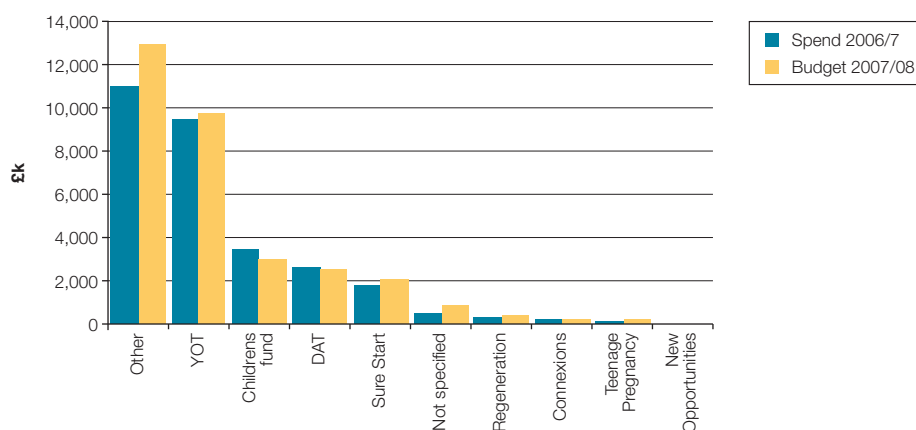
Fig. 3.2: Trends in total CAMHS expenditure and budget (PCT/LA)



Source of funding

- 3.11 The principle source of the CAMHS budget was mainstream funding, accounting for 94% of the total CAMHS spend in 2006/7, the same proportion as in the two previous years. The CAMHS investment from mainstream sources in 2006/7 was £492,717k. Of the remainder, the key sources were youth offending team (YOT) funding (2%), the Children's Fund (2%), Sure Start/Children's Centres funding (1%) and drugs and alcohol (DAT) funding 1%. Children's Fund and DAT funding was declining and all other sources were expected to increase in 2007/8 although expected growth was often small (Fig. 3.3).

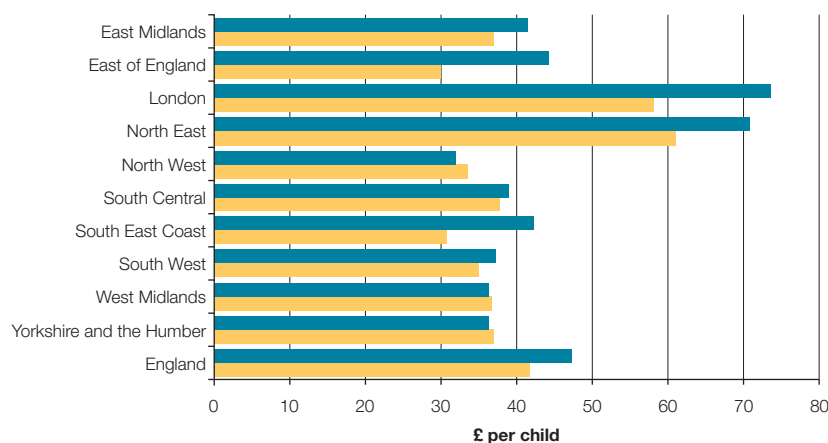
Fig. 3.3: Funding sources CAMHS spend 2006/7 and CAMHS budget 2007/8



Spend per child

3.12 PCT and local authority national CAMHS expenditure per child of the population aged 0 to 17 was £47.32 in 2006/7 with a PCT inter-quartile range of £26.26 to £48.43. This was a 13% increase on the 2005/6 figure of £41.71 per child (PCT inter-quartile range of £26.05 to £45.36). The SHA average showed large variation ranging from £31.99 to £73.63 (Fig. 3.4).

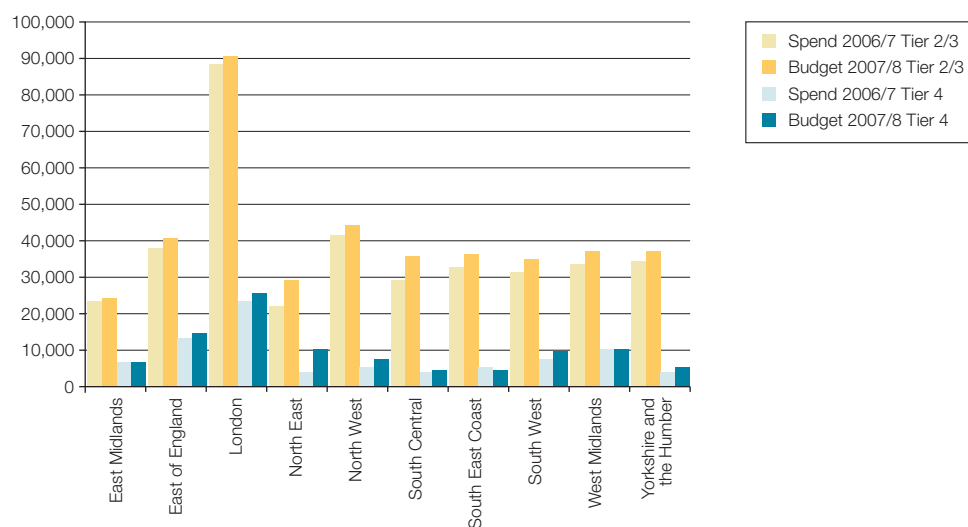
Fig. 3.4: Spend (£) per child (0-17): 2005/6 and 2006/7



Spend on tier 2/3 and tier 4 teams

3.13 Overall, expenditure on CAMHS tier 2 and 3 teams was £384,380k in 2006/7 (74% of total spend) and the predicted budget for 2007/8 was £420,436k. National expenditure on tier 4 units/teams was £91,039k in 2006/7 and expected to rise to £107,096k in 2007/8. In 2006/7 expenditure in London accounted for 23% of national spend on tier 2/3 teams and 25% of spend on tier 4 units/teams (Fig. 3.5).

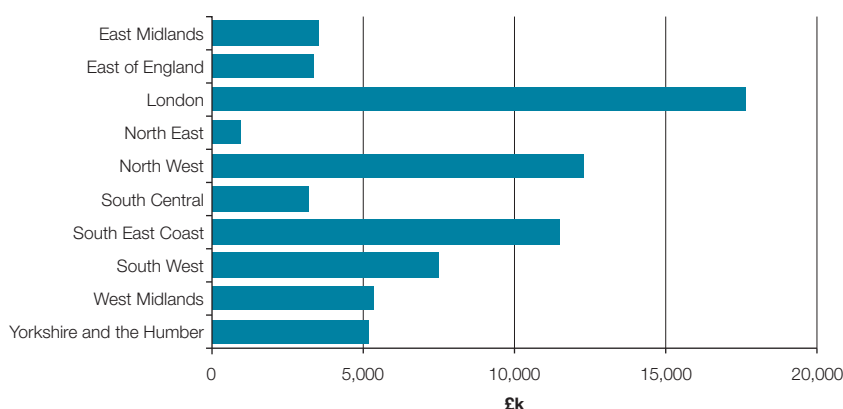
Fig. 3.5: Spend 2006/7 and budget 2007/8 on tier 2 and 3 and tier 4



Individual care

3.14 At the request of commissioners the mapping exercise collected information on expenditure on provision of mental health and emotional well being individual care packages. This included spot purchasing and whilst the majority was for out of area placements, some complex care packages were provided within localities. A total spend of £70m was reported for 2006/7, this marked a 36% increase on the £52m reported for 2005/6. In 2006/7, 79 PCTs reported individual care spend on CAMHS. The PCT mean was £413k and the inter-quartile range was £154k to £729k. Only 23 LAs reported CAMHS spend on individual care. The mean LA spend was £456k and the inter-quartile range was £168k to £1,219k. Regional variation ranged from just over £3,000k in the North East to £17,500k in London (Fig. 3.6). A possible explanation for this is that London is known to have significantly higher spending levels for individual or out of area care by education and social care services, whilst North East spend may reflect the provision of a wider range of resources.

Fig. 3.6: Individual care spend on mental health and emotional well-being (NSF Standard 9): 2006/7 by SHA



Chapter 4.

Workforce



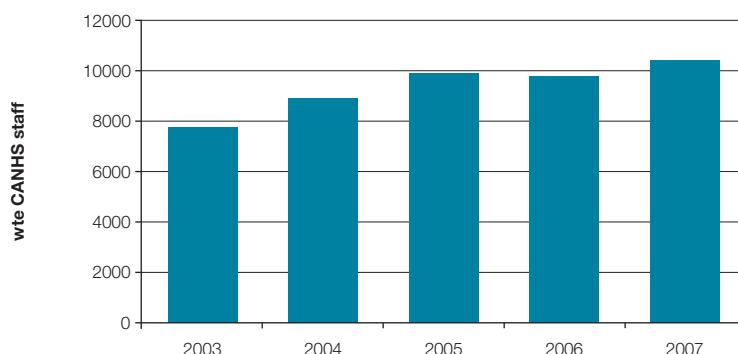
Introduction

- 4.1 This section explores the CAMHS workforce, looking in particular at its professional make-up and the distribution of professional staff across CAMHS teams. As staff are an integral part of any service, the mapping exercise has asked for workforce information from the outset. Information on the interdisciplinary nature of the workforce helps to explain the service being delivered and information on the staff team size provides an indicator of service capacity. However, only general data is collected and no information is recorded on the grades and qualification of staff, ensuring there are no confidential data on the open access mapping website.
- 4.2 This section provides information on:
- CAMHS workforce overview
 - Professionals in the CAMHS workforce
 - Workforce by team type
 - CAMHS care staff to all age population
 - National vacancy rates.
- 4.3 In the mapping, each service is asked to record the number of staff in post on 30th November. Bank staff and other temporary staff who are filling funded posts are included. Locums who are temporarily replacing a staff member who is still in post are excluded, as are unsalaried trainees. Staff are counted in terms of whole time equivalent (wte) and headcount but only wte are reported here.
- 4.4 To capture the interdisciplinary nature of services, staff numbers are recorded by professional group but it is the profession required by the post that should be recorded rather than the professional background of the post-holder. For example, a team manager who is a fully qualified psychiatric nurse would be recorded as a manager unless the post required mental health nurse qualification and experience. Similarly, staff whose time is split between more than one post or type of activity, should have their time apportioned accordingly. For example, a manager who works as a half-time manager and half-time nurse with clinical duties should be recorded as 0.5 wte manager and 0.5 wte nurse.
- 4.5 Services are also asked to apportion staff time appropriately when they work across services or units. This is particularly relevant for CAMHS staff contributing to more than one team on a sessional basis. Only the sessional input to a team should be counted.
- 4.6 Detailed tables of the data used can be found and downloaded from the CAMHS mapping website at: www.childrensmapping.org.uk/reports

CAMHS workforce overview

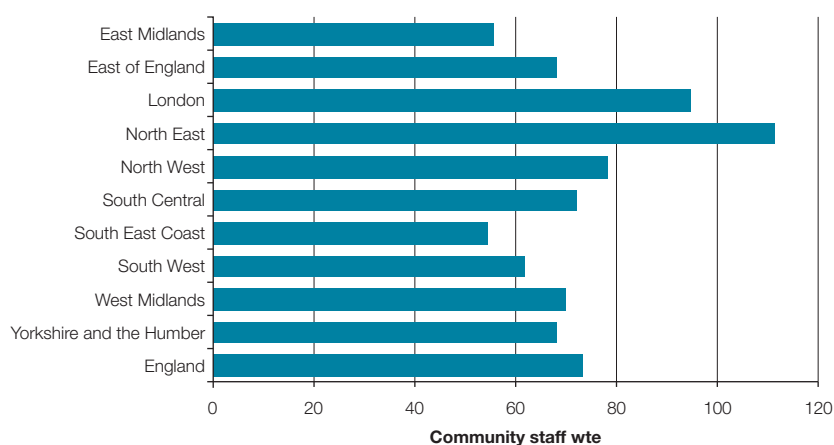
- 4.7 The total CAMHS workforce reported in 2007 was 10,375 wte, an increase of 579 wte (6%) on the previous year. There has been an increase of 2,613 wte (34%) since the 7,761 wte reported in the 2003 mapping exercise (Fig. 4.1).

Fig. 4.1: Total CAMHS workforce (wte) 2003-2007



- 4.8 Looking only at 'local' teams that serve a defined local population, nationally there was an average of 94 wte CAMHS staff per 100k population of 0-17 year olds in 2007. This indicated an increase from an average of 88 wte CAMHS staff per 100k population of 0-17 year olds in 2006, 89 wte in 2005 and 80 wte in 2004. The average in SHAs ranged from 61 to 165 wte per 100k population of 0-17 year olds (Fig. 4.2).

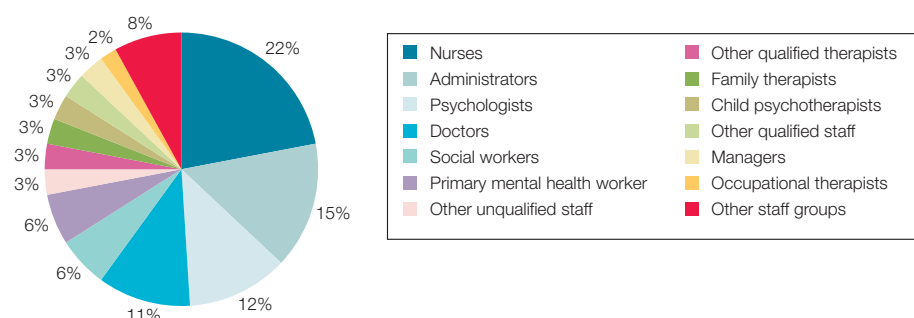
Fig. 4.2: Whole time equivalent (wte) staff in local teams per 100k 0-17 population



Professionals in the CAMHS workforce

- 4.9 In order to meet the diverse needs of children and young people, the CAMHS workforce is multi-professional with a range of specialists. Nurses are the largest professional group in CAMHS, accounting for 22% of the workforce in 2007 (28% in 2006, 26% in 2005 and 28% in 2004). The largest other professional groups were: administrators (15% in 2007, 16% in 2006, 2005 and 2004); clinical psychologists (12% in 2007 and 2006, 13% in 2005 and 14% in 2003); and doctors (11% in 2007 and 2006, 10% in 2005 and 11% in 2004) (Fig. 4.3).

Fig. 4.3: CAMHS workforce by profession, 2007



- 4.10 Following the full merger of CAMHS mapping with child health and maternity service mapping, the range of staff categories was expanded to describe a child health and maternity workforce. This led to some changes to the way staff were categorised resulting in 8% of the total CAMHS workforce reporting in new 'other child health staff groups'. Table 4.1 details the reported wte in post from 2003 and shows the changes that have been made to the workforce classification.

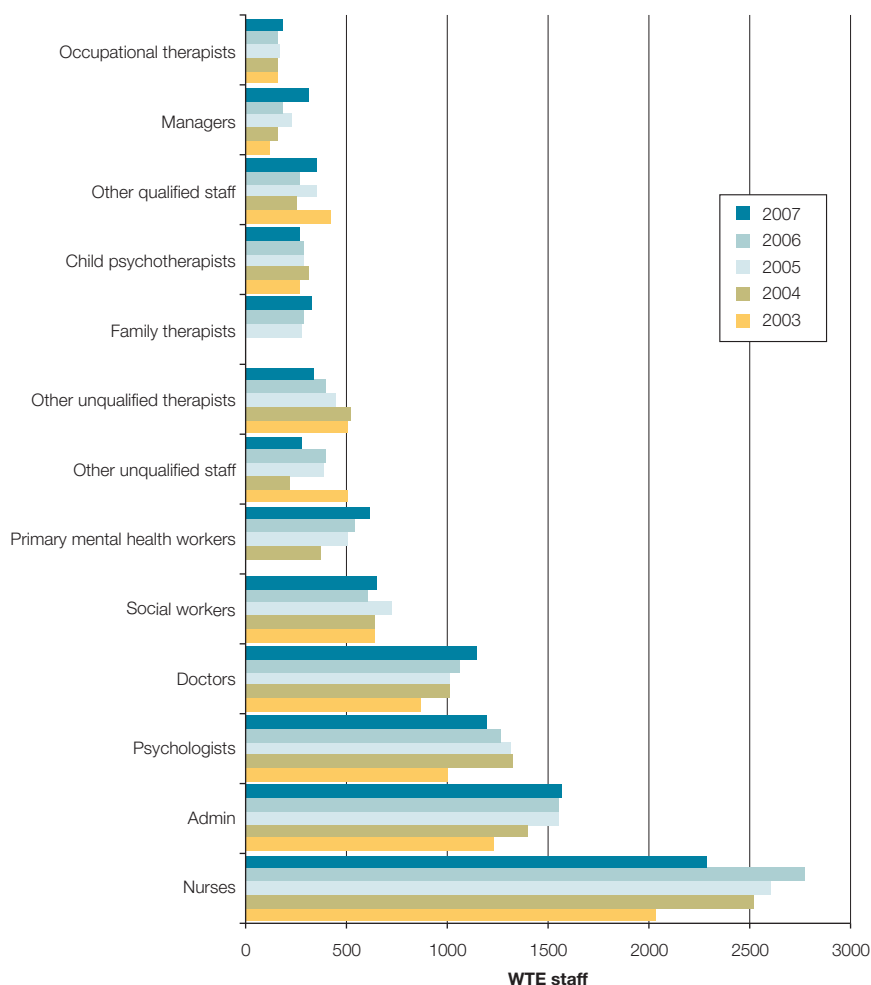
Table 4.1: CAMHS wte in post by profession 2003-2007

	2003	2004	2005	2006	2007	% change 2003 to 2007
Nurses	2038	2517	2600	2770	2268	11%
Admin	1230	1393	1552	1559	1558	27%
Psychologists	997	1320	1320	1269	1310	31%
Doctors	866	1008	1019	1064	1141	32%
Other child health staff groups	N/A	N/A	N/A	N/A	839	N/A
Social workers	638	640	722	599	641	0%
Primary mental health workers	N/A	382	506	548	617	N/A
Other qualified staff	426	254	352	262	404	-5%
Other qualified therapists	507	522	447	396	342	-33%
Family Therapists	N/A	N/A	274	296	325	N/A
Managers	120	161	227	188	314	162%
Other unqualified staff	511	219	394	400	509	0%
Child psychotherapists	270	312	289	287	265	2%
Occupational therapists	159	165	176	157	177	11%
Total workforce	7761	8894	9876	9796	10332	33%

4.11 Whilst the CAMHS workforce has increased substantially since 2003, the growth has been variable amongst professional groups (Fig. 4.4). However, some of the trends have been affected by the changes to the classification described above. For example, primary mental health workers were first mapped separately in 2004 and family therapists in 2005. The principal areas of growth in 2007 were as follows:

- The number of doctors increased from 1,064 wte in 2006 to 1,145 wte in 2007 (8%)
- Primary mental health workers (PMHW), a relatively new role, increased from 548 wte in 2006 to 619 wte in 2007 (13%)
- The social work workforce increased to 657 wte from 599 wte in 2006 but remained below the 722 wte recorded in 2005. This fluctuation in the number of social workers recorded could in part be due to changes in mapping structure when CAMHS mapping merged with child health and maternity service mapping in 2006
- The number of family therapists has shown a steady rise since they were first introduced as a separate category in 2005. In 2007 there were 326 wte, a rise of 10% on the 296 wte recorded in 2006. At the same time the number of 'other qualified therapists' has shown a steady decline
- The number of managers has fluctuated considerably over the last 4 years. This may be due in part to confusion about the inclusion of non-clinical team managers and the introduction on 2006 of guidance to count only the management time of managers who carry clinical caseloads.

Fig. 4.4: Change in CAMHS workforce by profession: 2003 to 2007



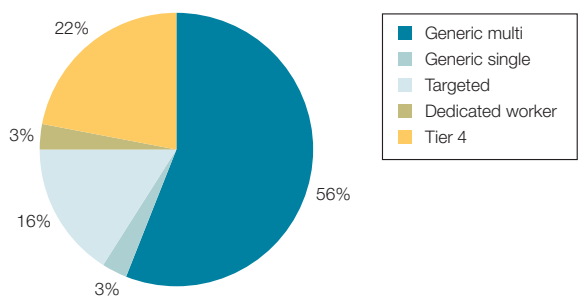
Workforce by team type

Box 2: Team type definitions

Generic team: Generic CAMHS teams meet a wide range of the mental health and psychological needs of children and adolescents within a defined geographical area. Generic (multi) teams are made up of CAMHS professionals from a number of disciplines who work together to ensure integrated provision. Generic (single) teams are single disciplinary groups of staff who provide a range of therapeutic interventions.
Targeted team: These teams provide for children with particular problems or requiring particular types of therapeutic intervention.
Dedicated worker team: Dedicated workers are fully trained CAMHS professionals who are out-posted in teams that are not specialist CAMHS teams but have a wider function, such as a youth offending team or a generic social work children's team.
Tier 4 team: These services provide longer term or more intensive provision. This may take the form of whole- or half-day activities, in-patient care, or outreach support (such as emergency or after care) which is considered an alternative to in-patient care. Some may provide more than one of these types of care.

4.12 The classification of CAMHS teams developed in the mapping exercise is described in Box 2. Multidisciplinary and single disciplinary generic teams account for the majority of the CAMHS workforce employing 59% of CAMHS staff (generic multidisciplinary teams employing 56% and single disciplinary generic teams employing 3%). Tier 4 teams have remained static with about 22% of the workforce. Staff in targeted teams and dedicated workers in non-CAMHS teams have been a growth area over this period from a combined workforce of 1,374 wte in 2003 to 1,971 wte in 2007. Targeted teams account for 16% of the CAMHS workforce and dedicated workers in non-CAMHS teams 3% (Fig.4.5).

Fig. 4.5: CAMHS workforce by team type



4.13 Administrators are the largest staff group in generic multidisciplinary teams (20% of the total workforce) followed by nurses (17%) and doctors (12%). Psychologists are the largest staff group in targeted teams (19%), followed by nurses (17%) and administrators (14%). Nurses account for 41% of the tier 4 workforce, doctors for 9% and administrative workers for 8% (Table 4.2).

Table 4.2: Professional breakdown of workforce by team type 2007

	Multi-disciplinary generic CAMHS team		Single-disciplinary generic CAMHS team		Targeted CAMHS team		Dedicated CAMHS worker		Tier 4 CAMHS Unit/team		Total CAMHS workforce	
2007	wte	%	wte	%	wte	%	wte	%	wte	%	wte	%
Nurses	941	16%	12	4%	318	19%	74	22%	941	41%	2286	22%
Administrators	1144	20%	50	16%	186	11%	25	7%	158	7%	1563	15%
Clinical psychologists	627	11%	142	44%	245	15%	49	15%	87	4%	1149	11%
Doctors	833	14%	-	0%	86	5%	4	1%	222	10%	1145	11%
Other staff groups	144	2%	8	2%	151	9%	9	3%	527	23%	839	8%
Social workers	405	7%	5	2%	185	11%	13	4%	49	2%	657	6%
PMHWs	442	8%	37	12%	40	2%	96	29%	5	0%	619	6%
Other qualified staff	192	3%	29	9%	81	5%	13	4%	40	2%	354	3%
Other qualified therapists	191	3%	12	4%	88	5%	6	2%	46	2%	342	3%
Family therapists	240	4%	2	0%	47	3%	9	3%	29	1%	326	3%
Managers	202	3%	7	2%	52	3%	18	5%	37	2%	315	3%
Other unqualified staff	120	2%	1	0%	92	6%	4	1%	64	3%	282	3%
Psychotherapists	207	4%	1	0%	39	2%	5	1%	15	1%	267	3%
OT	106	2%	2	1%	13	1%	3	1%	56	2%	181	2%
Educational psychologists	17	0%	11	4%	13	1%	8	2%	-	0%	49	0%
Current total staff	5808	100%	320	100%	1636	100%	335	100%	2276	100%	10375	100%

4.14 There were a total of 427 generic multidisciplinary teams reported in 2007, employing 5,808 wte staff, giving an average team size of 14 wte. However, taking care staff only, there was an average of 10 wte care staff per generic multidisciplinary team. The average staffing in single discipline generic teams was 6 wte overall and 5 wte care staff. The majority of single disciplinary teams were made up of psychologists and administrative staff, accounting for 48% and 16% of the total workforce respectively (Fig. 4.6 and Table 4.3).

4.15 Targeted teams accounted for the second highest number of teams in the mapping, although they usually employed much smaller numbers of workers. There were 314 targeted teams in 2007, employing 1,636 wte total staff and 1397 wte care staff, giving a mean of 5 wte per targeted team. Psychologists were the largest staff group in targeted teams, followed by nurses and then administrative workers.

ⁱⁱ Care staff are defined as all qualified and unqualified staff in post, excluding admin and managers.

Fig. 4.6: Average size of the CAMHS staff teams by team type 2003 to 2007 (wte)

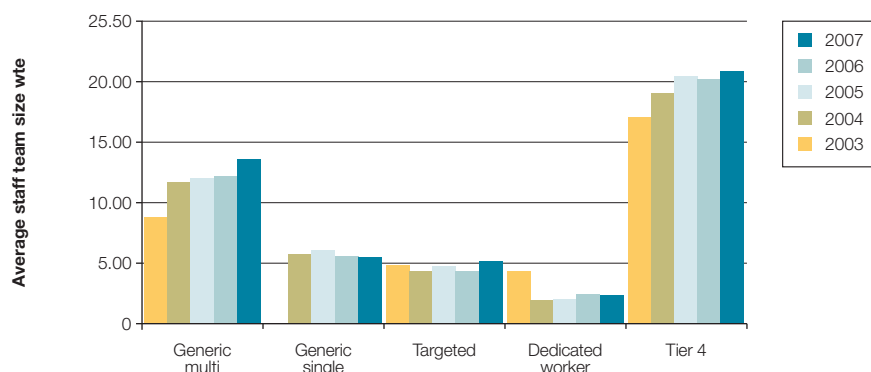


Table 4.3: Average number of wte in CAMHS staff teams by team type 2007

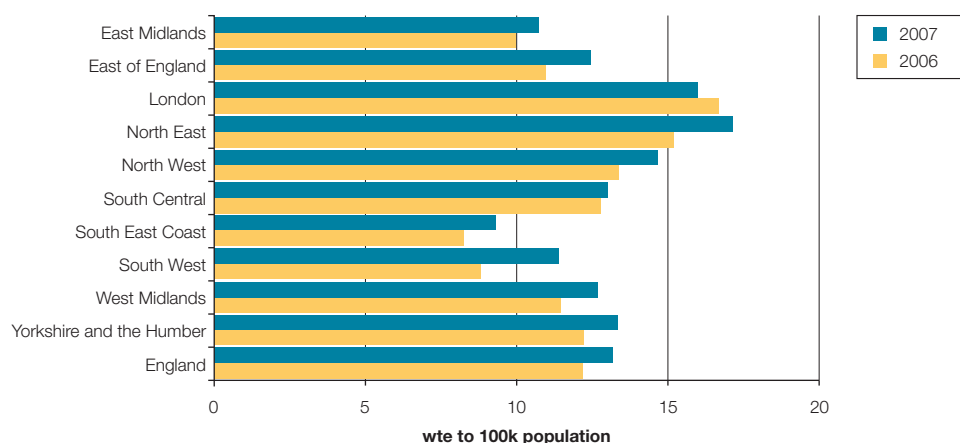
2007	Number of teams	Total workforce (wte)	Care staff (wte)	Mean number of wte total workforce per team	Mean number of wte clinical workers per team	Share of total workforce (%)	Share of clinical workforce (%)
Generic - multidisciplinary	427	5808	4463	14	10	56%	53%
Generic - single discipline	58	320	263	6	5	3%	3%
Targeted	314	1636	1397	5	4	16%	16%
Dedicated	139	335	292	2	2	3%	3%
Tier 4	109	2276	2081	21	19	22%	24%
Total	1047	10375	8496	10	8	100%	100%

- 4.16 The 139 dedicated CAMHS workers in non-CAMHS teams had a total workforce of 335 wte, giving an average workforce of 2 wte per team. Dedicated worker teams include only the specialist CAMHS input into non-specialist mental health teams, such as youth offending teams or community paediatrics. PMHWs accounted for 29%, the largest share of the dedicated worker workforce. Nurses and psychologists were also common dedicated CAMHS workers. The 109 tier 4 teams employed 2,276 wte staff giving an average of 21 wte and 19 wte care staff.
- 4.17 The overall picture was of a workforce expanding its role in the community, retaining its existing disciplines and adding new staff types which are creating flexibility to target specific groups of young people and problems.

CAMHS care staff to all age population

- 4.18 Care staff are defined as all qualified and unqualified staff in post, excluding administrative staff and managers. The NSF sets out guidelines for levels of staffing in tier 3 CAMHS provision. These propose that generic specialist multidisciplinary CAMHS at tier 3 with teaching responsibilities and providing evidence-based interventions for 0-17 year olds would need a minimum of 20 wte care staff per 100,000 total population, and a non-teaching service, a minimum of 15 wte care staff⁷. However, it is acknowledged that it is not straightforward to estimate the numbers of care staff needed for viable multidisciplinary teams at tier 3 that meet local demands, and provide a sustainable service. Much depends on the local demography, demand and the range of services available within the area.
- 4.19 No specific tier 3 service data are collected in the mapping as the original pilot study found that teams operated across tiers and within broad team types. Therefore local teams have been used as a proxy for tier 3 services as many deliver elements of tier 3 and deliver to a defined local population.
- 4.20 Counting care staff only, the number of staff per 100k population in local CAMHS teams was 13.2 wte in 2007. This has increased steadily from 10.2 wte in 2004 to 11.7 wte per 100k in 2005 and 12.2k in 2006. A large degree of variation remains across SHA area, ranging from 8.3 to 16.7 wte per 100k in 2006 and from 9.3 to 17.1 wte in 2007 (Fig. 4.7).

Fig. 4.9: Funded vacancy rates in the CAMHS workforce by SHA 2006 and 2007



National vacancy rates

Definition of vacancy:

A vacancy is a funded post which a service is actively seeking to fill.

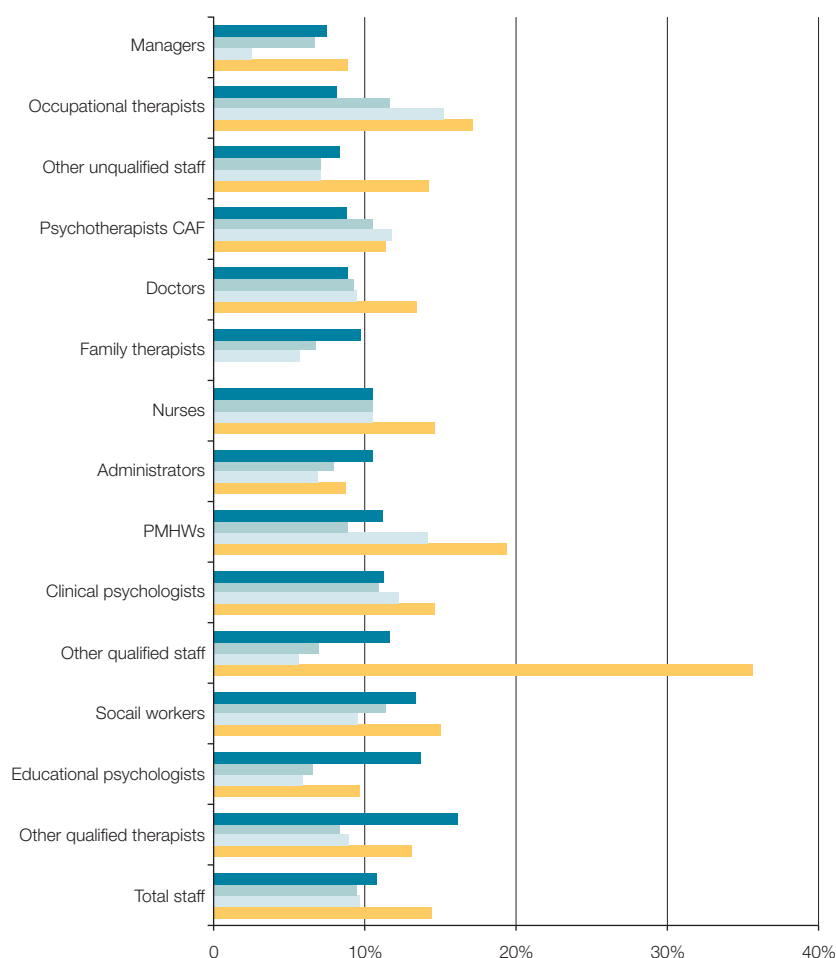
- 4.21 After a steady decline in the vacancy rate amongst CAMHS staff, the rate showed an increase in 2007. The vacancy rate as the proportion of vacancy posts within the overall funded establishment rose from 9% in 2006 to 10% in 2007, reverting to its 2005 rate (Table 4.4). The number of funded vacancies dropped from 2,169 wte in 2003 to 1,490 wte in 2004, 1,045 wte in 2005, and 1,011 wte in 2006, before increasing to 1,114 wte in 2007.

Table 4.4: Trends in CAMHS staffing and vacancy rates: 2003 to 2007

Vacancies	2003	2004	2005	2006	2007
Total staff (wte)	7761	8894	9876	9705	10375
Total staff (vac)	2169	1490	1045	1011	1114
Funded establishment	9930	10384	10921	10716	11489
Vacancy as % of wte in post	28%	17%	11%	10%	11%
Vacancy as % of wte funded establishment	22%	14%	10%	9%	10%

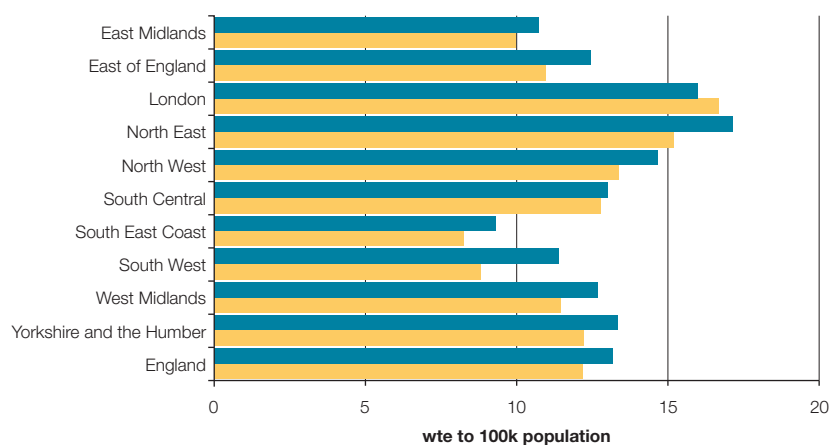
- 4.22 Considerable variation was found in the vacancy rates of specific professional groupings (Fig. 4.8). Other qualified therapists had the highest vacancy rate (16% in 2007, up from 8% in 2006). Whilst educational psychologists account for a very small proportion of the overall CAMHS workforce, they had the second highest vacancy rate at 14% in 2007. This was considerably higher than the 7% vacancy rate reported in 2006. Social workers had the third highest vacancy rate at 13%, marginally higher than the rate of 11% reported in 2006.
- 4.23 The vacancy rate for both doctors and nurses has stayed relatively constant over the last three years. The rate for doctors has remained at 9% in 2005, 2006, and 2007. The rate for nurses fell to 10% in 2007, from 11% in 2005 and 2006. The vacancy rate for social workers increased to 11% in 2006, from 10% in 2005 and 15% in 2004 (Fig.5.8f). Managers continue to have the lowest vacancy rate, although this continues to rise, to 7% in 2007, from 6% in 2006 and just 3% in 2005.

Fig. 4.8: Funded vacancy rates by profession in the CAMHS workforce: 2004 to 2007



4.24 Regional variation was apparent in the overall vacancy rate of staff, ranging from over 5.7% to 12.3% (Fig. 4.9).

Fig. 4.9: Funded vacancy rates in the CAMHS workforce by SHA 2006 and 2007



Chapter 5.

Towards comprehensive CAMHS provision



Standard 9

“All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multidisciplinary mental health services to ensure effective assessment, treatment and support, for them, and their families. ”

National Service Framework for Children, Young People and Maternity Services

Introduction

- 5.1 This chapter describes the teams that make up the specialist tier 2 to 4 component of CAMHS provision using the five team-type classification developed for the mapping exercise explained in para. 2.12 and 2.13 and defined in para. 4.12.
- 5.2 The section reports the findings as follows:
- Trends in the provision of specialist CAMHS
 - Tier 4 services
 - Alternatives to inpatient care
 - Proxy indicators of a comprehensive CAMHS
 - ADHD and autistic spectrum disorder provision
 - Youth offending
 - Looked after children
 - Team settings
 - Parenting programmes.
- 5.3 In this chapter, the data is reported at national and SHA levels only. Detailed tables of the data used can be found and downloaded from the mapping website at: www.childrensmapping.org.uk/reports.

Trends in the provision of specialist CAMHS

- 5.4 In 2007, 1,047 specialist CAMHS teams were reported, 1% less than the 1,055 teams mapped in 2006. This was the first year a fall in the number of CAMHS teams had been reported since the first mapping collection in 2003. Only targeted teams continued to increase, with the number of teams growing 10% from 267 in 2005 to 290 in 2006 and a further 8% to 314 in 2007 (Fig. 5.1). Generic CAMHS teams, dedicated CAMHS staff working in non-CAMHS settings and tier 4 services (tertiary services providing hospital inpatient care and intensive treatments) all declined by between 3 and 4%.
- 5.5 Trends in the workforce of teams reflect the growth of targeted teams and the decline of dedicated CAMHS workers working in non-CAMHS settings but the number of staff working in generic teams showed an increase (Fig. 5.2). This indicated that a number of generic teams have been reconfigured, with teams merging to make larger units. In 2007, 17 generic teams and 21 targeted teams reported that they had been reconfigured. Only 7 generic teams had been newly resourced, compared to 16 targeted teams and 10 dedicated workers.

Fig. 5.1: Trends in provision of CAMHS tier 2 to 4 provision 2003 to 2007

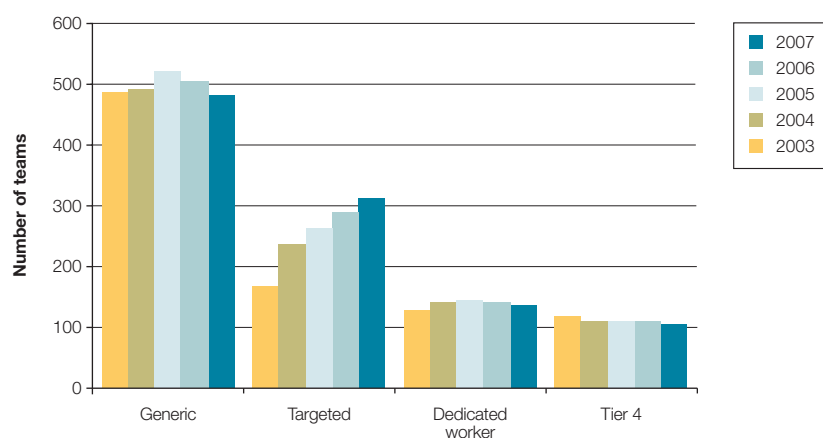
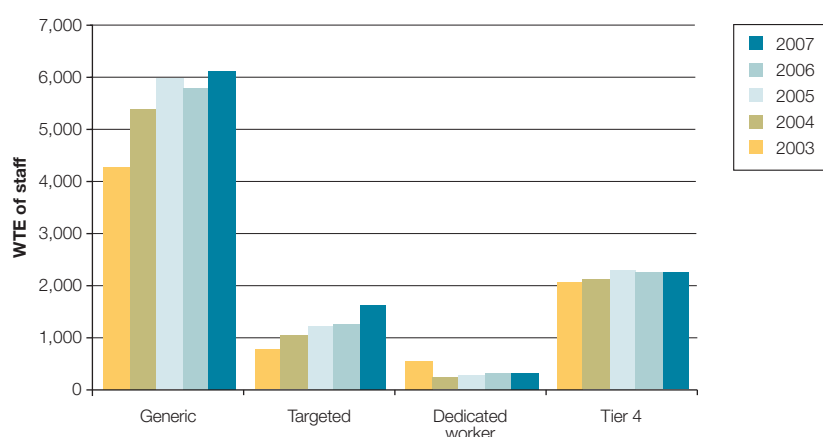
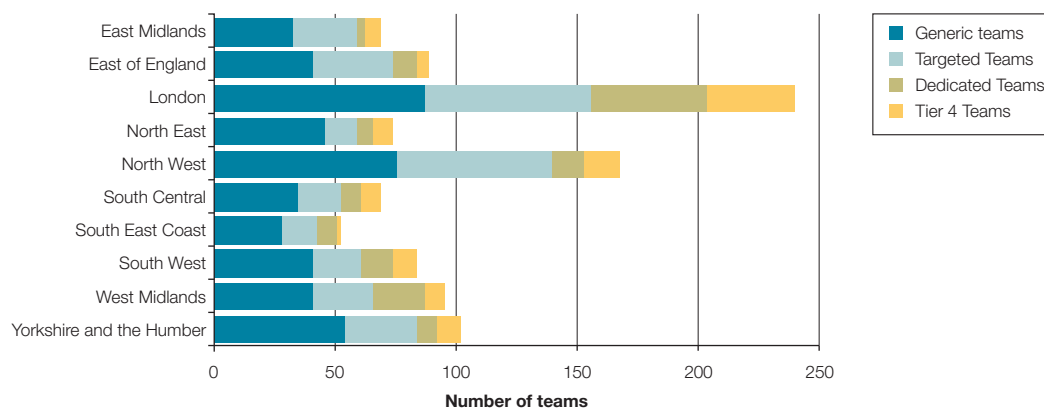


Fig. 5.2: Trends in the workforce of CAMHS tier 2 to 4 provision 2003 to 2007



5.6 The provision of team types in SHAs shows the uneven distribution of teams around the country due in part to variations in team size. In 2007, 23% of teams were provided in London and 16% in the North West (Fig. 5.3) where the average team size was 9.1 wte and 9.0 wte respectively while the West Midlands and the North East had average team sizes of 11.6 wte and 12.3 wte respectively. Fig 5.3 also illustrates differences in the models of services that have developed in regions. In England, 46% of teams were generic teams, 30% targeted, 13% dedicated workers and 10% tier 4 units/teams. However, in the North East, 62% of teams were generic. In the East of England and the East Midlands, 37% of teams were targeted and in the South West and London, over 20% of teams were dedicated CAMHS workers.

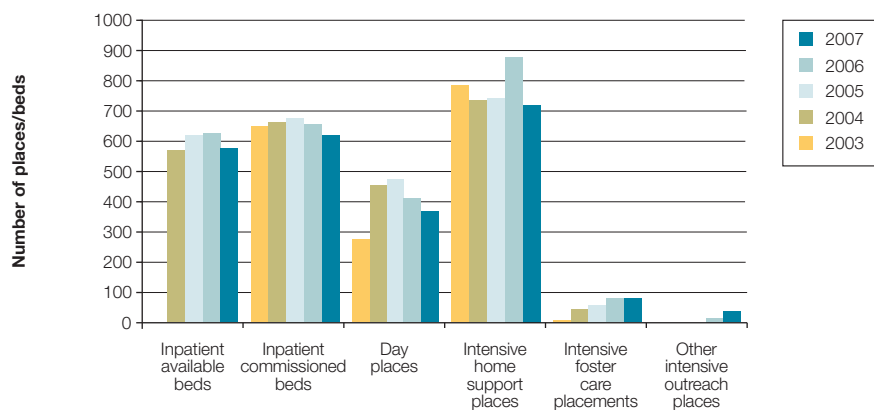
Fig. 5.3: Provision of tier 2 to 4 CAMHS teams by SHA 2007



Tier 4 services

- 5.7 There has been a continued fall in the number of tier 4 services mapped since 2005 but it is important to note that mapping only collects NHS and not independent sector provision and therefore only gives a partial picture of national provision. The number of commissioned inpatient beds fell from the 2005 high of 680, to 659 in 2006 and 621 in 2007. Day places dropped from 478 in 2005, to 415 in 2006 and 368 in 2007 (Fig. 5.4). During the same period the provision of intensive home support rose from 747 places in 2005 to 879 places in 2006, but then fell back to 724 places in 2007. The number of intensive foster care places continued to increase from 64 in 2005 to 83 places in 2006 and 86 places in 2007.

Fig. 5.4: Trends in capacity of CAMHS tier 4 provision 2003 to 2007



- 5.8 There was uneven NHS tier 4 provision across SHAs. The highest provision of inpatient beds was in the North East with 0.11 beds per 100k population aged 0 to 17, and London with 0.08 beds per 100k but the West Midlands had as little as 0.01 beds per 100k (Table 5.1). Forensic CAMHS beds were located in 3 SHAs only. Provision of day places ranged from 5 to 87 places per SHA, intensive home support from 6 to 250 places and intensive foster places from none to 30 places.

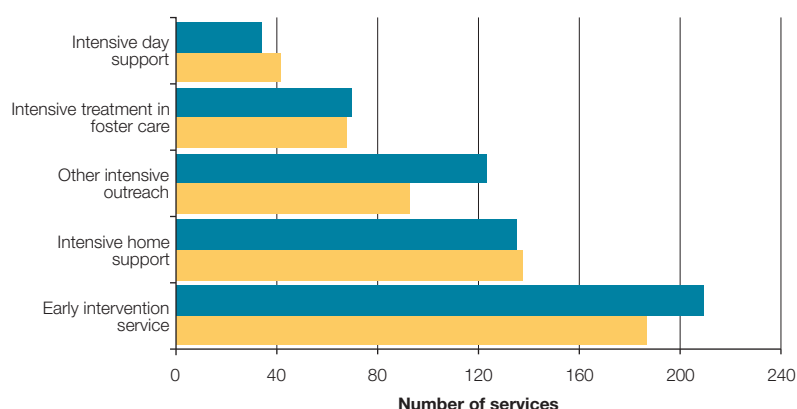
Table 5.1: Number of beds and places in CAMHS tier 4 provision 2007

	No. Tier 4 Teams	Number of commissioned beds	Number of forensic beds commissioned	Number of other beds commissioned	Day Places	Intensive home support places	Intensive foster care places	Other intensive outreach places	pop 0-17 100k	Inpatient beds per 100k aged 0 to 17
East Midlands	6	28	-	4	18	6	-	-	929.91	0.03
East of England	6	45	-	-	10	250	4	-	1220.95	0.04
London	35	133	20	9	87	33	30	-	1630.64	0.08
North East	8	61	-	2	22	-	-	-	543.05	0.11
North West	15	57	10	-	68	183	15	-	1534.21	0.04
South Central	8	47	-	12	37	66	30	20	876.69	0.05
South East Coast	2	19	-	-	5	90	-	-	917.37	0.02
South West	10	50	-	-	40	30	-	22	1059.91	0.05
West Midlands	9	18	20	36	5	27	7	-	1213.78	0.01
Yorkshire & Humber	10	44	-	6	76	39	-	-	1121.8	0.04
Total	109	502	50	69	368	724	86	42	11048.31	0.05

Alternatives to inpatient care

5.9 In addition to tier 4 provision, alternatives to inpatient care were provided by generic, targeted and dedicated worker teams (at tiers 2 and 3). In total, 359 (38%) CAMHS tier 2/3 teams were providing alternatives to inpatient care, an increase from the 312 (33%) providing this support in 2006. Altogether, 210 teams were providing early intervention services (up from 187 the previous year), 135 intensive home support, 70 intensive foster care, 34 intensive day support and 123 teams provided other forms of intensive outreach (Fig. 5.5).

Fig. 5.5: Provision of alternatives to inpatient care 2006 and 2007



Proxy indicators of a comprehensive CAMHS

- 5.10 In 2007/8, Children's Services Mapping provided the third year of data collection to monitor the development of a fully comprehensive CAMHS as specified in Public Service Agreement (PSA) 12. The measure, known as the PAF A70 indicator focused on four elements of CAMHS known as the proxy indicators. These proxies referred to the provision of:
- On-call and emergency response services
 - Services that are appropriate for the level of maturity of young people aged 16 and 17 years
 - Specialist services for children and young people with learning disabilities and mental health problems
 - Partnership arrangements for the support of children and young people with complex needs.
- 5.11 Information on the proxy indicators was collected in a number of ways so that the data could be triangulated to form a more complete picture of service development. PCTs were required to submit data through their quarterly Local Delivery Plan Returns (LDPR). Local authorities reported progress through CAMHS mapping and this indicator, the PAF A70, contributed to the local authority Annual Performance Assessment (APA) rating. Information on the proxy indicators was also collected from NHS CAMHS providers but in 2007 for the first time this information on organisation-wide provision was collected using the four point scale used by the local authority PAF A70 indicatorsⁱⁱⁱ. The local authority and NHS trust returns are reported below.

On-call provision and emergency response

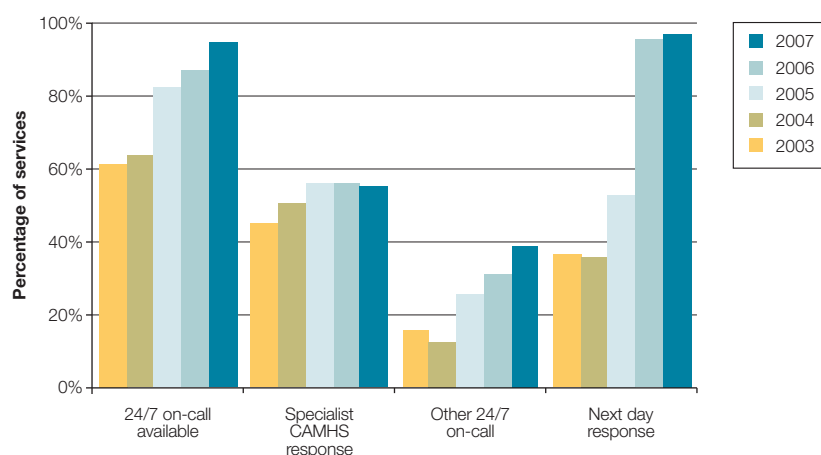
Children and young people presenting as emergencies or as requiring urgent assessment and intervention include: those who have rapidly developed a serious or life-threatening condition; those whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support.

National Service Framework for Children, Young People and Maternity Services⁸

- 5.12 Steady progress has been reported in the provision of on-call and emergency response services by NHS CAMHS providers. In 2003, just 63% of CAMHS providers reported an on-call service and this had risen to 95% in 2007 (Fig. 5.6). The proportion of services that could provide a response by a CAMHS professional had also risen from 46% in 2003 to 56% in 2007, but this provision showed no improvement on 2005 or 2006. Appointments on the next working day for children and young people who needed urgent assessment or treatment rose sharply in 2006 and increased slightly in 2007 to provision in 97% of services.

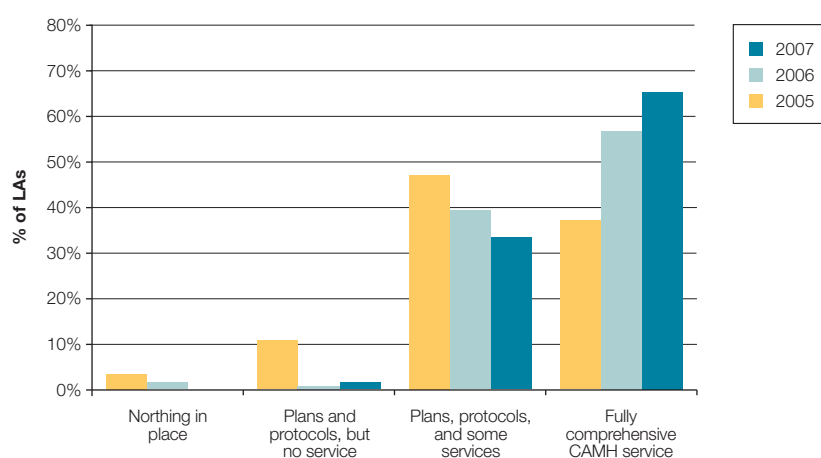
ⁱⁱⁱ **Rating scale: 1:** No service in place OR strategic plans to address the issue; **2:** Plans and protocols in place but services have yet to be developed; **3:** Plans and protocols in place and some services; **4:** A fully comprehensive CAMH Service available covering whole area.

Fig. 5.6: Trends in on-call CAMHS provision 2003 to 2007



- 5.13 In 2007, only 2% of NHS providers reported no services, protocols or plans in place for an on-call CAMHS. A further 4% of NHS providers had plans and protocols but no services in place, 34% had some on-call services in place with some still to be developed and 61% had a fully comprehensive on-call service available. 56% of NHS on-call services were staffed by CAMHS professionals.
- 5.14 Next working day appointments for children and young people needing emergency care or assessment were offered by 76% of NHS providers where fully comprehensive services were available and in 21% of trusts where some services were in place. One percent of NHS trusts reported no services, protocols or plans in place for a next day response and 2% did not answer this question.
- 5.15 In local authorities 65% reported fully implemented on-call services available throughout their area (up from 57% in 2006 and 37% in 2005). A further 33% of LAs had plans and protocols in place and partially implemented services (down from 39% in 2006 and 47% in 2005). Only 1% of LAs had plans and protocols but no services in place (the same number as in 2006 but down from 11% in 2005) and no LAs had nothing in place for CAMHS on-call (down from 1% in 2006 and 3% in 2005) (Fig. 5.7).

Fig. 5.7: Trends in local authority provision of CAMHS on-call and emergency response 2005 to 2007



- 5.16 In 2007, a total of 513 (49%^{iv}) CAMHS teams contributed to the on-call provision, up from 448 in 2006. Of the teams contributing to an on-call response, 316 (62%) were generic multidisciplinary teams, 77 (15%) were tier 4 teams and 101 (20%) were targeted teams. It was interesting to note that over 70% of all tier 4 and generic teams contributed to an on-call service.

Services for people of sixteen and seventeen years of age

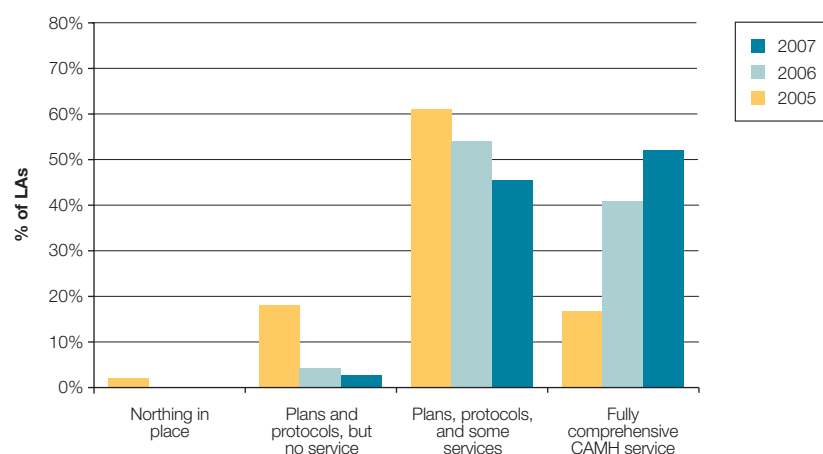
A degree of flexibility is clearly required to ensure that young people receive treatment in an environment that promotes their engagement and responds to their developmental needs. This means that some young people may wish to exercise choice about which service feels most appropriate to them.

NSF for Children, Young People and Maternity Services 2004⁹

- 5.17 The provision of age appropriate services for 16 and 17 year olds became a proxy measure for the provision of a comprehensive CAMHS in 2005 in response to national concerns about the adequacy of the service to meet the particular mental health needs of young people of this age in transition between children and adult services. There is no prescription of the services to be provided but key elements should include:
- Services appropriate for the developmental needs of 16 and 17 year olds
 - Local arrangements for handling referrals
 - Smooth transition between CAMHS and adult services at the appropriate age
 - Collaboration with early intervention teams for young people with early onset psychosis
 - The use of the Care Programme Approach for young people leaving inpatient care
 - Appropriate attention to child protection needs of young people.
- 5.18 Since 2005, the provision of age appropriate care for 16 and 17 year olds has risen steadily. In 2005 47% of CAMHS providers reported provision, rising to 84% in 2006 and 90% in 2007. 49% of NHS providers provided fully comprehensive age appropriate CAMHS and 41% provided some services, with other services still to be developed. 2% of NHS trusts had plans and protocols in place, but were yet to implement them, while 7% had no services, plans or protocols for age appropriate 16/17 CAMHS provision.
- 5.19 The number of individual teams reporting appropriate provision for 16 and 17 year olds increased from 338 (32%) in 2005 to 553 (52%) in 2006 and 745 (71%) in 2007. There were 18,106 young people aged 16 to 18 on the CAMHS caseload, 17% of the total caseload.
- 5.20 Transition arrangements were in place in 447 teams (43%) and of these 299 (67%) had agreed the arrangements with the local authority.
- 5.21 Local authorities were also asked about the provision of services within the council area for 16 and 17 year olds who require mental health services appropriate for their age and level of maturity. 78 local authorities (52%) had fully comprehensive CAMHS for 16 and 17 year olds across the whole council area, up from 25 (17%) in 2005 and 61 (41%) in 2006. 68 (45%) local authorities had plans, protocols and some services and 4 (3%) had plans and protocols but no services (Fig. 5.8). There were no local authorities with nothing in place.

^{iv} Not asked of dedicated workers in non-CAMHS teams (N.=144)

Fig. 5.8: Trends in local authority development of CAMHS appropriate for 16 and 17 year olds 2005 to 2007



Learning disability provision

There is a need to ensure that children and young people with learning disability who require psychiatric care have access to appropriate services that meet their needs and that they are not disadvantaged because of their disability.

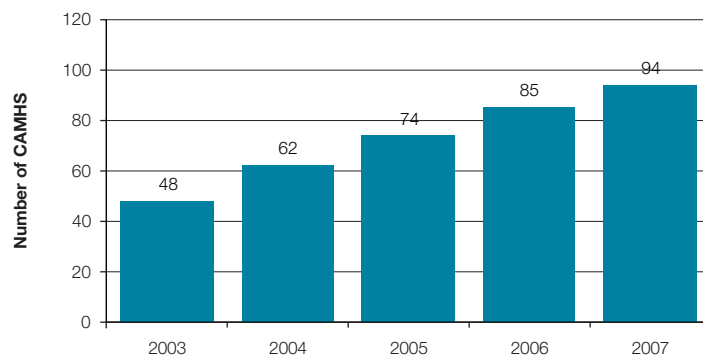
NSF for Children, Young People and Maternity Services 2004¹⁰

5.22 The NSF stresses the importance of equity of access to CAMHS for children and young people with both mental health needs and learning disabilities. Adequate provision would be expected to include:

- Adequate provision of mental health promotion and early intervention
- Specialist staff training for both tier 2/3 and tier 4 staff
- Adequately resourced tiers 2 and 3 learning disability specialist CAMHS
- Access to tier 4 services providing in-patient, day-patient and outreach units.

5.23 There has been steady growth in the number of NHS CAMHS that provide specialist provision for children and young people with mental health problems and learning disabilities. The number of providers with these services has risen from 48 in 2003 to 94 in 2007 (Fig. 5.9). Of the 112 NHS CAMHS providers, 94 (87%) reported having specialist learning disability provision. 36 providers (33%) had a fully comprehensive service and 59 (54%) had some services in place, with others still to be developed. 3 (3%) trusts had plans and protocols but no learning disability services and 9 (8%) NHS providers had no services, plans or protocols.

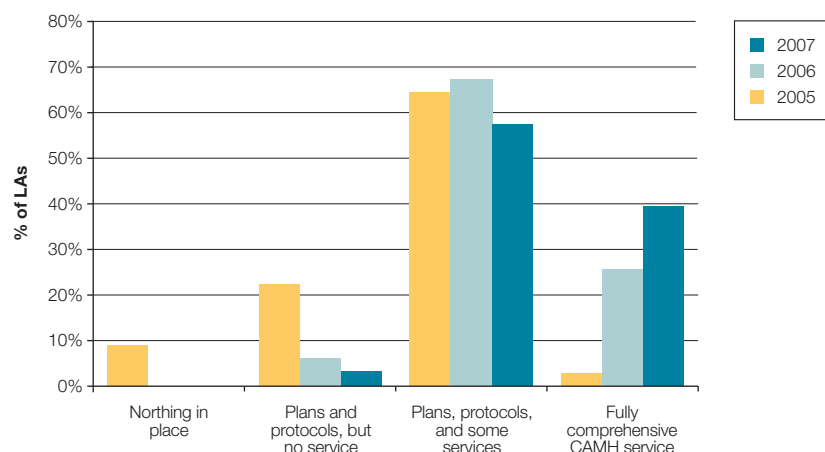
Fig. 5.9: Trends in the development of CAMHS for children and young people with learning disabilities 2003 to 2007



5.24 In 2007, a total of 722 CAMHS teams (69% of all teams) provided specialist learning disability care, an increase from 590 (55%) teams in 2006 and 346 (33%) teams in 2005. In 2007, CAMHS worked with 9,455 children and young people with a learning disability. The proportion of the CAMHS caseload identified as learning disabled increased from 8% in 2005 to 9% in both 2006 and 2007.

5.25 59 (39%) local authorities had fully comprehensive provision for learning disabled children and young people with mental health problems and 86 (57%) had plans and procedures in place but were yet to ensure provision throughout the LA area (Fig. 5.10). 35 (3%) local authorities reported no specialist learning disability and mental health provision but plans were in place.

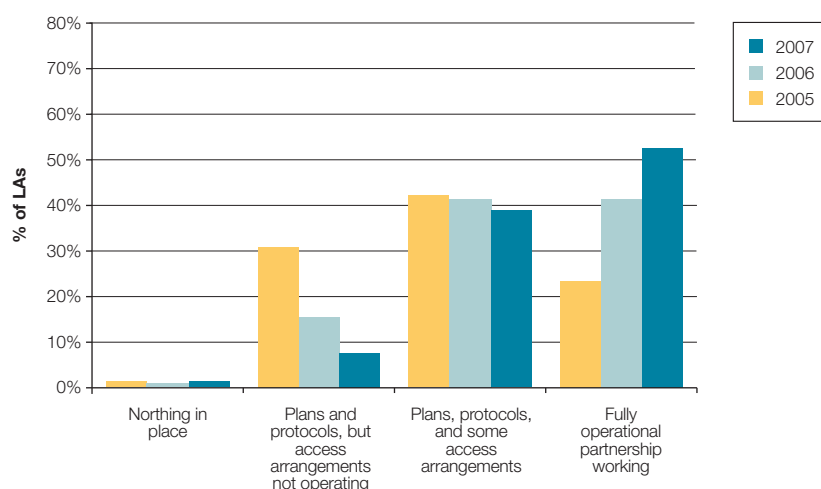
Fig. 5.10: Trends in local authority arrangements for and provision of CAMHS learning disability services 2005 to 2007



Complex needs

5.26 Local authorities reported improved arrangements for and provision of services for children and young people with complex needs. The number with fully operational partnership working throughout their area rose from 35 (23%) in 2005 to 62 (41%) in 2006 and 79 (53%) in 2007. A further 58 (39%) local authorities had plans and procedures in place and some access arrangements. 11 (7%) local authorities had plans and procedures but their access arrangements were not operating and 2 (1%) had neither services nor plans (Fig. 5.11).

Fig. 5.11: Trends in local authority arrangements for and provision of services for children with complex needs 2005 to 2007



ADHD and autistic spectrum disorder provision

5.27 The number of children and young people with attention deficit hyperactivity disorder (ADHD) being supported by CAMHS teams increased in 2007 to 17,450 cases (16% of the total caseload) from 14,170 in 2006 (13%). 727 CAMHS teams (69%) reported ADHD cases on their caseload in 2007 with the size of ADHD caseloads ranging from 1 to 266.

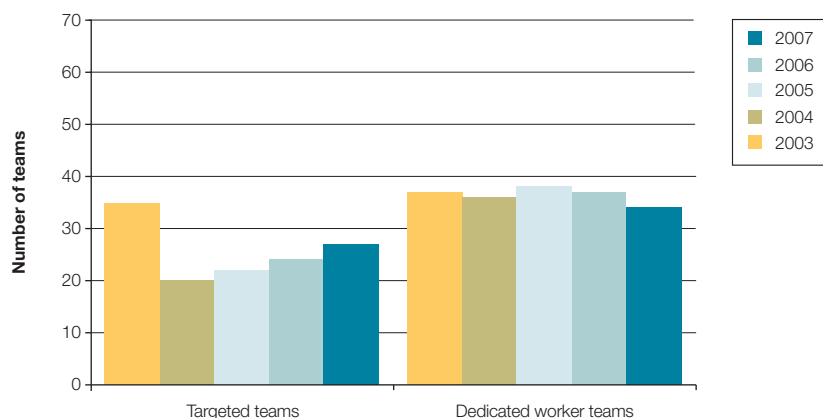
5.28 The number of children and young people supported with an autistic spectrum disorder (ASD) also increased from 7,719 in 2006 (7% of total caseload) to 10,231 in 2007 (9%). 685 CAMHS teams supported autistic spectrum disordered children and young people and their families, with caseloads ranging from 1 to 145. However, only 108 CAMHS teams reported providing targeted work for children and young people with an autistic spectrum disorder.

5.29 Recognising that children and young people with ADHD and ASD may be supported by paediatric services, questions were included in the child health mapping exercise on the provision of ADHD and ASD clinics. ADHD clinics were reported in 183 (52%) of the 349 community paediatric services and 193 (55%) ran ASD clinics.

Youth offending

- 5.30 Since 2004 there has been a small but steady increase in the number of targeted CAMHS teams that have a focus on working with young offenders from 20 to 27 in 2007, suggesting the questions were misunderstood in 2003 (Fig. 5.12). In the same period the number of dedicated CAMHS workers working in non-CAMHS teams with a focus on youth offending decreased from 38 teams in 2005 to 34 in 2007.

Fig. 5.12: Trends in CAMHS teams with a focus on youth offending 2003 to 2007

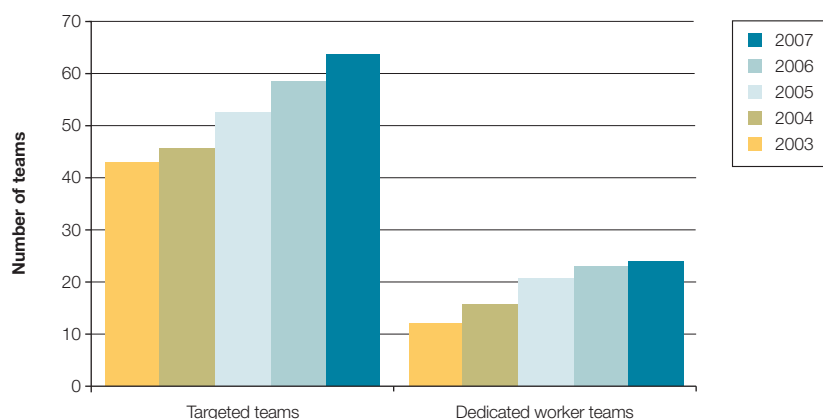


- 5.31 In 2007 there were 6,019 young offender cases being supported by CAMHS teams during the sample period. This was a reduction of 3% from the 6,203 cases recorded in 2007. 53% of the cases were supported by generic teams, 24% by targeted teams, 14% by dedicated CAMHS workers in non-CAMHS teams (such as youth offending teams) and 9% by tier 4 units.

Looked after children

- 5.32 There has been steady growth in the number of social services teams and teams with a focus on looked after children reported in CAMHS mapping since 2003 (Fig. 5.13). The number of targeted teams increased from 43 in 2003 to 64 in 2007 and the number of dedicated CAMHS workers in social services or looked after children's teams doubled from 12 to 24.

Fig. 5.13: Trends in CAMHS teams with a focus on social services and looked after children 2003 to 2007



- 5.33 The number of looked after children on CAMHS team caseloads in the sample period was 9,339 in 2007, 9% of the total caseload. This was a reduction of 1% on the previous year when 9,405 cases were recorded. 55% of cases were from generic teams, 32% from targeted teams, 6% from dedicated CAMHS worker teams and 6% from tier 4 units.

Team settings

- 5.34 Although CAMHS teams tend to be based in health settings, 76% being located in hospitals or community health services/buildings (Fig. 5.14), teams were increasing their accessibility through outreach work in a wide range of community settings (Fig. 5.15). 49% of teams outreached into other health settings such as, community health centres and GP practices. 37% of teams provided outreach in education settings, 34% in mainstream primary and secondary schools, 18% in special schools, 13% in extended mainstream schools and 9% in extended special schools. 28% of teams provided home visits on a regular basis, 11% worked in children's centres, 7% in secure residential settings and 9% with youth offending teams.

Fig. 5.14: Settings of the main bases of tier 2 to 4 CAMHS teams 2007 (N=1040)

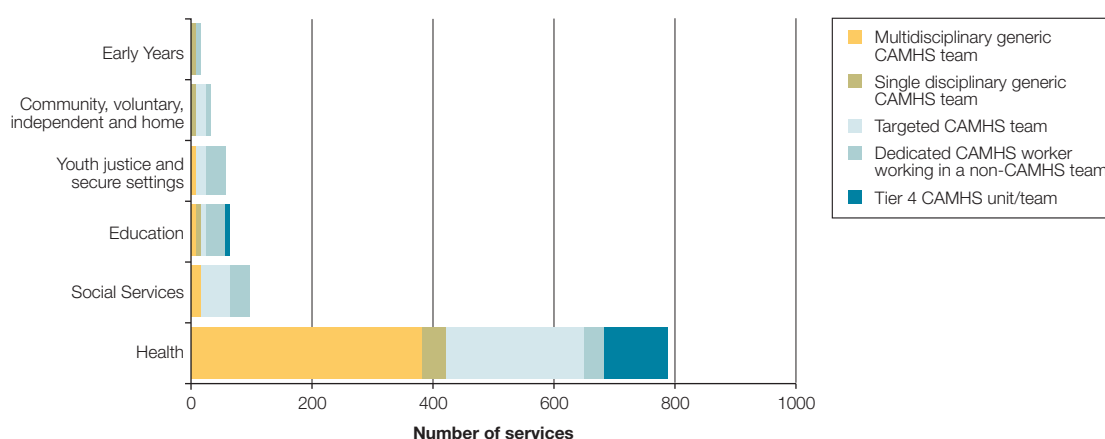
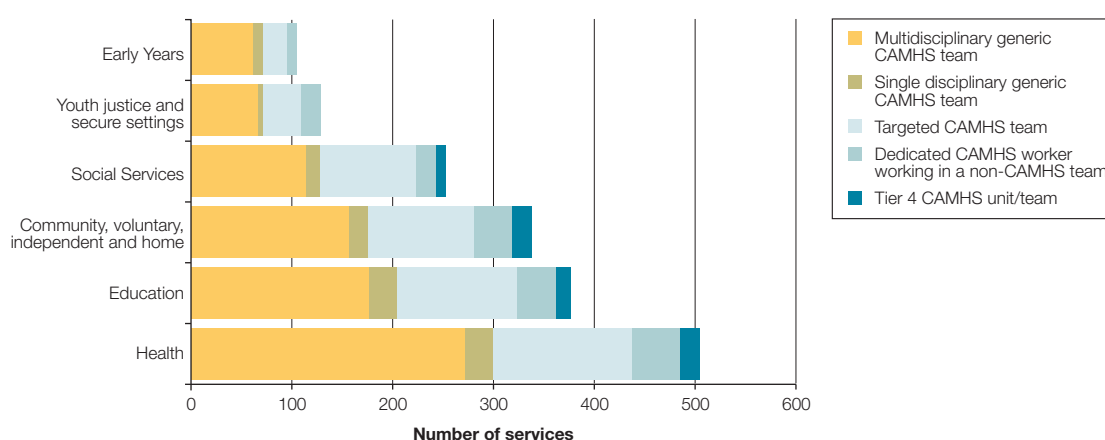


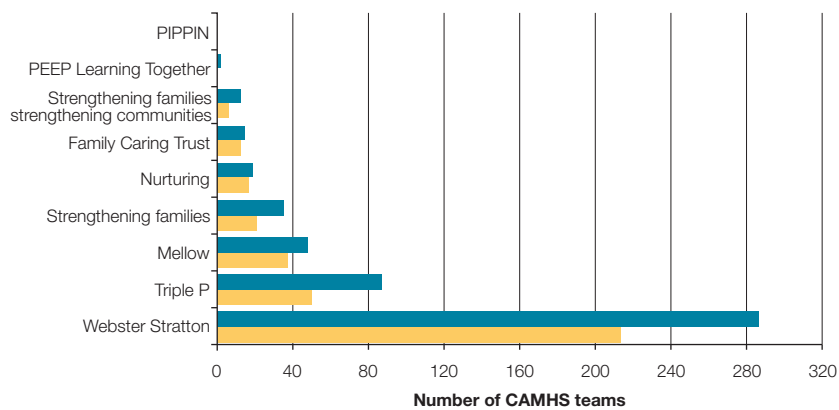
Fig. 5.15: Settings in which tier 2 to 4 CAMHS teams provided outreach 2007 (N=1040)



Parenting programmes

5.35 The provision of structured parenting programmes by CAMHS teams was growing. In 2006, 366 teams (35%) provided programmes and this had risen to 467 teams (45%) in 2007. Webster Stratton remained the most commonly provided programme, and the largest increase was in the number of teams delivering this intervention (Fig. 5.16).

Fig. 5.16: The types of structured parenting programmes delivered by tier 2 to 4 CAMHS teams 2006 and 2007



Chapter 6.

Functions and interventions



Introduction

- 6.1 The team classification used in CAMHS mapping was designed to give a broad description of the types of teams provided but it does not describe the work that teams undertake. Therefore, questions were added to the mapping exercise in 2006 at the request of service commissioners and managers to explore what functions and interventions were provided. Information on the use of outcome measures to assess the impact of interventions for children and young people was also collected.
- 6.2 This section reports on the following:
- Assessment
 - Consultation and liaison
 - Interventions
 - Training
 - Use of outcome measures.
- 6.3 Detailed tables of the data used in the following chapter can be found in the CAMHS topic report section of the website at: www.childrensmapping.org.uk/reports.

Assessment

- 6.4 Teams were asked to record the provision of eight types of assessment and the most commonly used were general initial assessments, psychological, psychiatric and high risk assessments (Fig. 6.1). Overall, 976 CAMHS teams (93%) undertook general initial assessments. These were provided occasionally by 127 teams (12%) and on a regular basis by 849 teams (81%). Psychological assessments were carried out by 829 teams (75%) overall and by 658 (63%) at least weekly, while psychiatric assessments were provided by 685 (65%) with 540 teams (52%) carrying them out at least weekly. High risk assessments were provided by 842 teams (76%) and on a regular basis by 516 teams (49%).
- 6.5 Assessments for court proceedings were provided by 547 teams (52%), for the Care Programme Approach (CPA) by 480 teams (46%) and for Education Act proceedings by 460 teams (44%). An increased number of teams were reported to be delivering all types of assessment investigated (Fig. 6.2).

Fig. 6.1: Percentage of CAMHS teams providing assessment functions at least weekly and less often 2007 (N=1047)

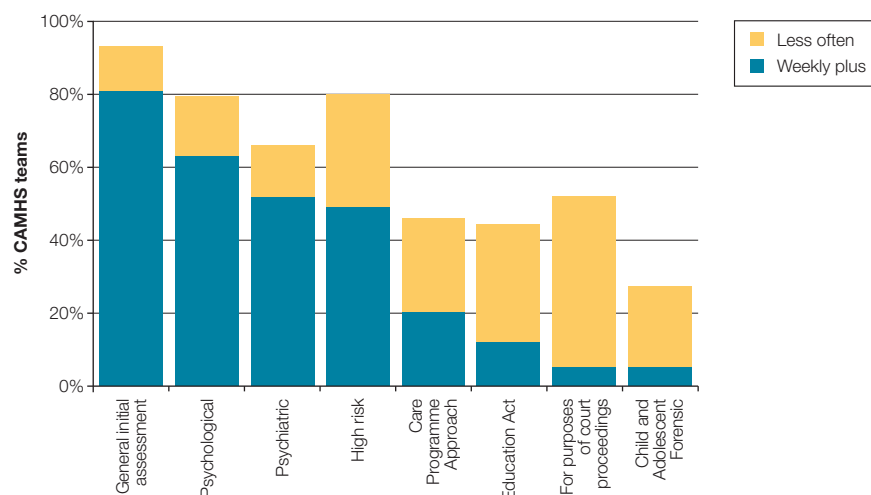
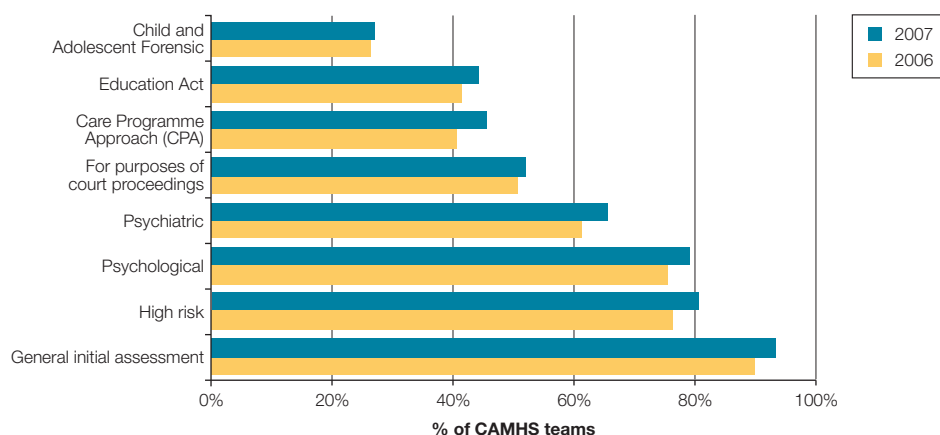


Fig. 6.2: Percentage of CAMHS teams providing assessment functions 2006 and 2007

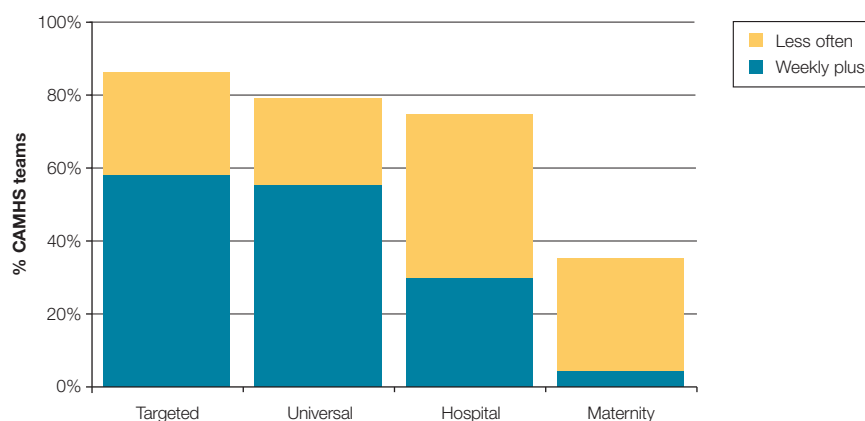


Consultation and liaison

Consultation and liaison with children's health services

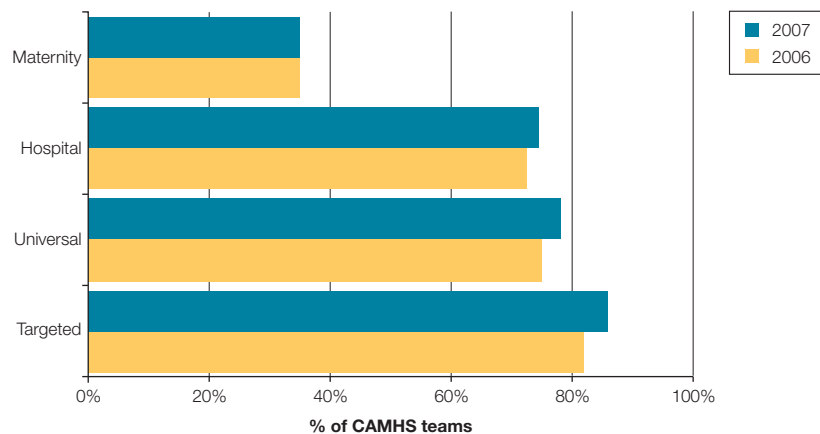
6.6 An important role for specialist CAMHS professionals is to provide consultation and liaison with other children's services and very strong links were reported with children's targeted, universal and specialist services. 893 teams (86%) provided consultation and liaison with children's targeted services, of which 601 teams (58%) had contact more than once a week (Fig. 6.3). Consultation and liaison was provided for universal children's services by 814 teams (78%) with 55% having at least weekly contact, and for children's hospital services by 774 teams (74%) with 30% having weekly contact. Provision for maternity services was less frequent with 363 teams (36%) providing some contact but only 39 teams (4%) provided contact on a weekly basis.

Fig. 6.3: Percentage of CAMHS teams providing consultation and liaison to health services at least weekly and less often 2007 (N=1047)



- 6.7 The number of teams providing consultation and liaison to maternity services remained stable between 2006 and 2007 but increasing activity was recorded with all other child health services (Fig. 6.4).

Fig. 6.4: Percentage of CAMHS teams providing consultation and liaison to health services 2006 and 2007



With education services

- 6.8 Consultation and liaison with schools and other educational settings was less widespread than consultation with health services but 877 teams (84%) reported working with secondary schools, 829 teams (80%) with special schools and 773 teams (74%) with primary schools (Fig. 6.5). Contact with primary and secondary schools tended to be more frequent than with special schools. 675 teams (65%) supported extended schools, 22% on at least a weekly basis. Increased consultation and liaison activity was reported in 2007 compared to the previous year (Fig. 6.6).

Fig. 6.5: Percentage of CAMHS teams providing consultation and liaison to education services at least weekly and less often 2007 (N=1047)

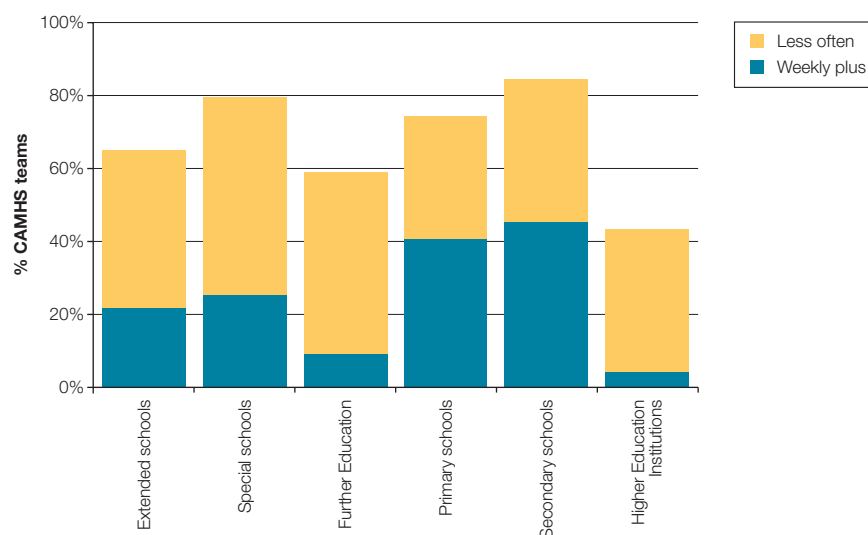
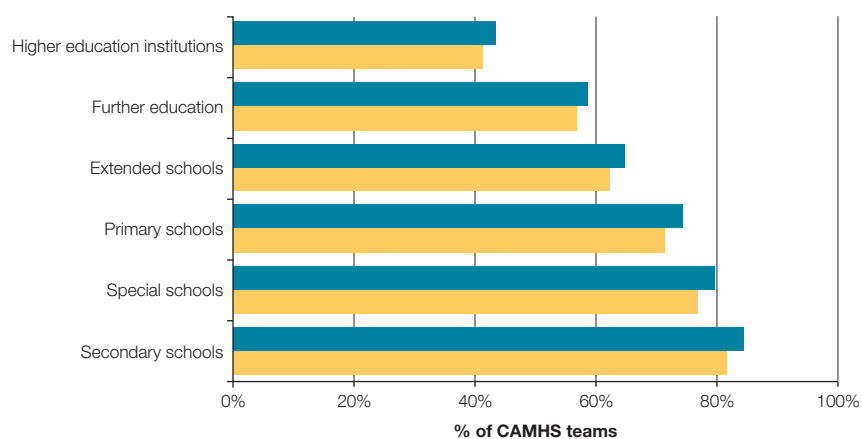


Fig. 6.6: Percentage of CAMHS teams providing consultation and liaison to education services 2006 and 2007



With other children's services

6.9 Contact with other children's services showed that over 70% of CAMHS teams provided consultation and liaison with a range of children's services including: looked after children's services (79% of teams); special needs services (76%); learning disability services (76%); Connexions (75%); education support services such as BEST (74%); youth offending services (73%); and disability services (71%). However the frequency of contact was lower (Fig. 6.7). The proportion of CAMHS teams providing this contact increased slightly between 2006 and 2007 (Fig. 6.8).

Fig. 6.7: Percentage of CAMHS teams providing consultation and liaison to other children's services at least weekly and less often 2007 (N=1047)

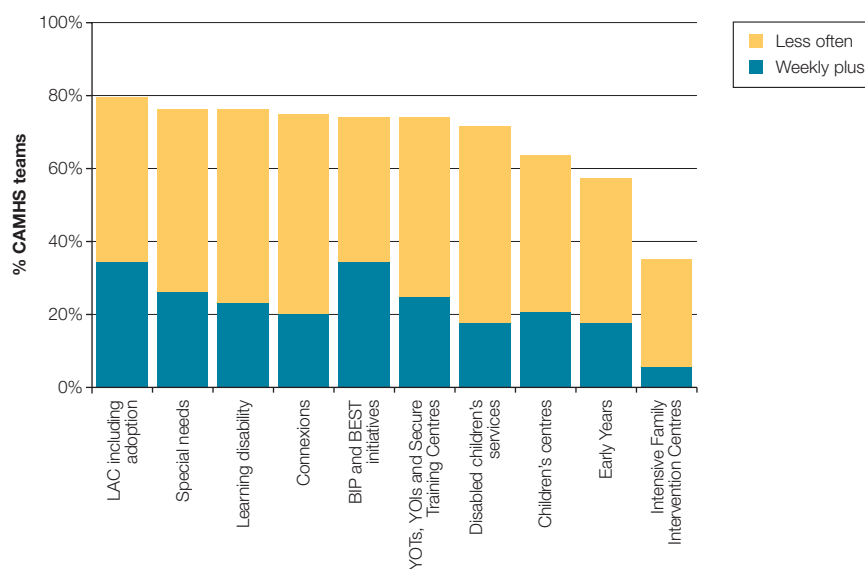
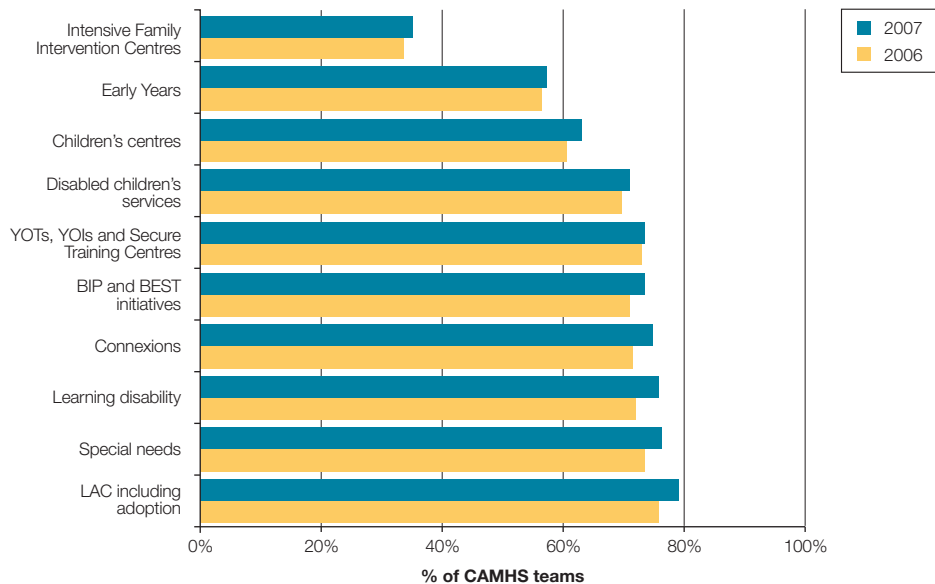


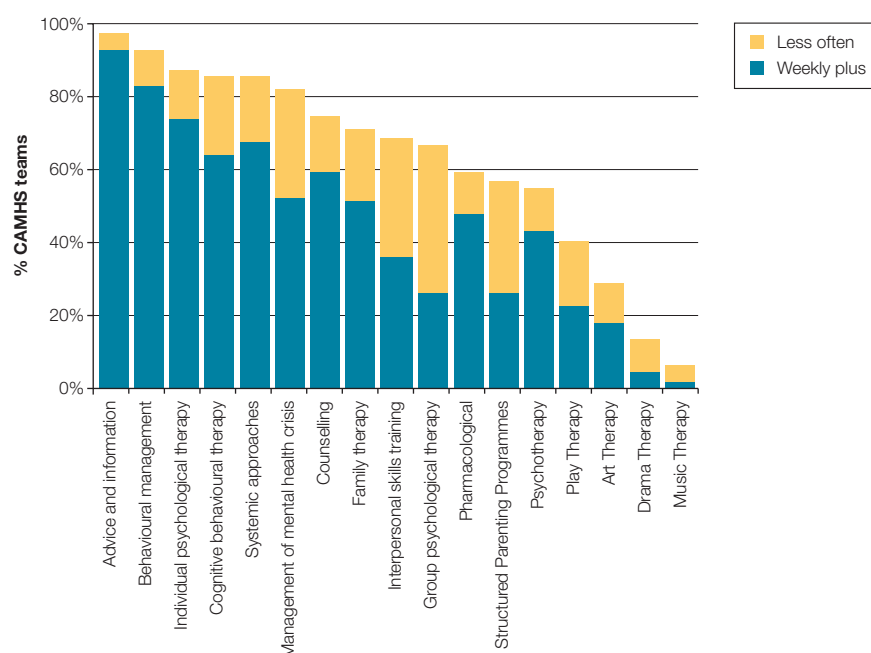
Fig. 6.8: Percentage of CAMHS teams providing consultation and liaison to other children's services 2006 and 2007



Interventions

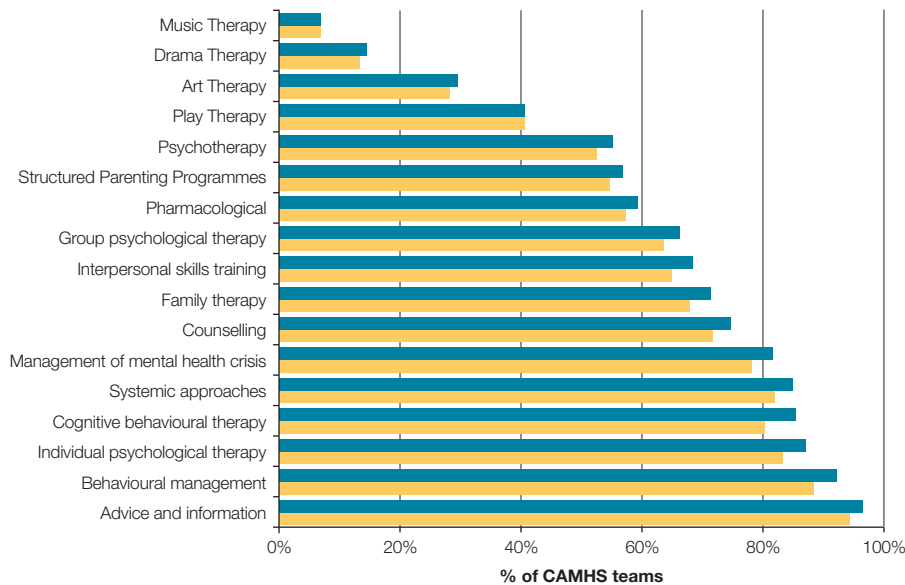
6.10 The majority of CAMHS teams were found to be providing the interventions listed in the mapping at least occasionally (Fig. 6.9). The interventions were largely therapies or particular therapeutic orientations, except for advice and information which was provided at least weekly by 93% of services. The most common therapeutic interventions to be provided were behavioural management, individual psychological therapy, systemic approaches, CBT, counselling and family therapy, all of which were delivered by over half of the CAMHS teams at least weekly. Play, art, drama and music therapy were the least likely to be provided.

Fig. 6.9: Percentage of CAMHS teams providing a range of specific interventions at least weekly or less often



6.11 Increased use of all interventions was reported between 2006 and 2007 (Fig. 6.10).

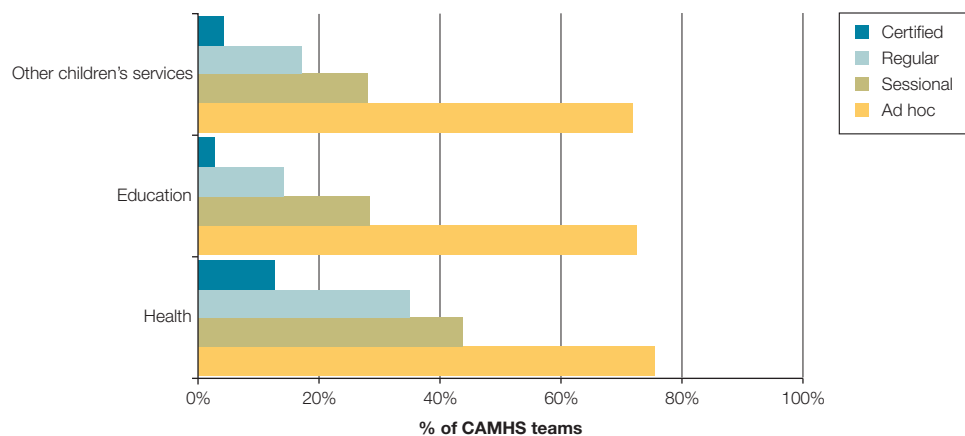
Fig. 6.10: Percentage of CAMHS teams providing a range of specific interventions 2006 and 2007



Training

6.12 CAMHS professionals are an important source of training for children's health, education and other services. Over 70% of CAMHS teams provided training on an ad hoc basis to all sectors of children's services but CAMHS staff were more likely to be involved in the training of health service staff than the staff of educational or other children's services (Fig. 6.11). 44% of CAMHS teams provided sessional input into health service training programmes, 35% delivered a regular component of a training course and 13% delivered a certified programme. Only 28% of CAMHS teams had sessional input into education service courses, 14% provided regular input and 3% provided a certified programme. 28% of CAMHS teams delivered sessional training to other children's services, 17% delivering a regular component and 4% providing a certificated course.

Fig. 6.11: Percentage of CAMHS teams providing training for children's services 2007 (N=1047)

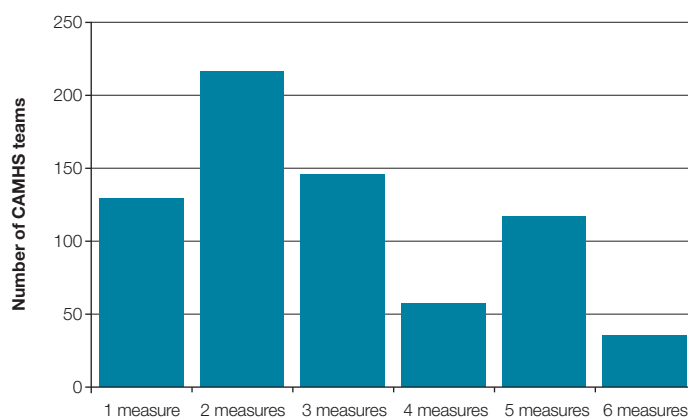


Use of outcomes measures

Use of outcome measures

- 6.13 One of the recommendations of the 2008 CAMHS review was to give strong support to the ongoing work of developing outcome measures for children's mental health and psychological well-being services. An aim of the 2007 PSA target (no12) is to improve the health and wellbeing of children. In order to evaluate the outcome of CAMHS, teams are being encouraged and supported to use standard measures to routinely collect information about changes in children's emotional wellbeing and experience of services. The measures collect information from three perspectives:
1. those of children and young people
 2. those of parents and
 3. those of clinicians.
- 6.14 Overall, 699 teams (67%) reported the use of at least one standard outcome measure, up from 623 teams (59%) in 2006. 129 teams (18%) used just one measure, 216 teams (31%) used 2 measures, 145 teams (21%) used 3 measures and 209 teams (31%) used 4 or more measures (Fig. 6.12). This shows a small increase in the number of teams using outcome measures since this question was introduced in 2006.

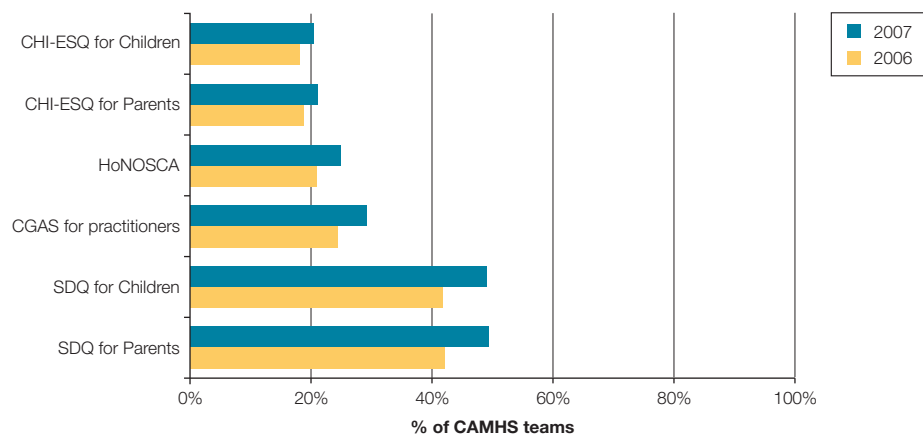
Fig. 6.12: The number of outcome measures being used by CAMHS teams 2007 (N=1047)



- 6.15 The outcome measures used were as follows:
- The SDQ for Parents and Children (Strengths and Difficulties Questionnaire) is used to assess change in the strengths and difficulties encountered by children. The children's questionnaire is used with 11 to 18 year olds and the parents' questionnaire with the parents/carers of children aged 3 to 16. In 2007, 518 teams (49%) used SDQ for parents, up from 445 teams in 2006. SDQ for children was used by 442 teams in 2006 rising to 514 (49%) in 2007 (Fig. 6.13).
 - CGAS, the Children's Global Assessment Scale, is a measure completed by practitioners to capture change in difficulties. It can be used on children and young people of all ages and is a way of rating the extent of child and family difficulties at the start of contact and six months later in order to evaluate change. It was used by 259 teams (24%) in 2006 and 307 teams (29%) in 2007.
 - Use of the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was reported by 221 teams (21%) in 2006 and 261 (25%) in 2007.
 - CHI-ESQ, the Commission for Health Improvement Experience of Service Questionnaire, is a method of capturing the views of children and parents on their experiences of services. It is used with children and

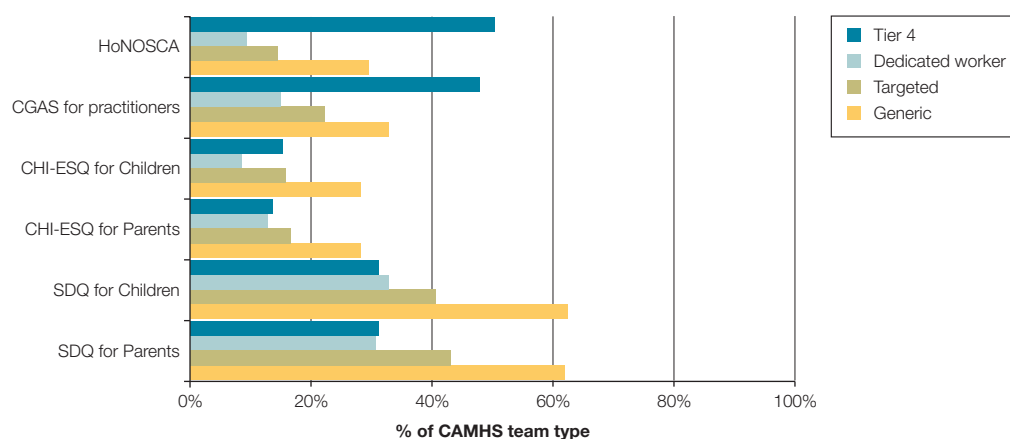
young people over the age of 9 and with the parents of younger children. Use with parents was reported by 198 teams (19%) in 2006 rising to 222 teams (21%) in 2007. It was used with children by 191 teams (18%) in 2006 and 214 (20%) in 2007.

Fig. 6.13: Use of outcome measures by CAMHS teams 2006 and 2007



- 6.16 SDQ measures were being used by over 60% of generic CAMHS teams and over 40% of targeted teams but by just over 30% of dedicated worker teams and tier 4 units/teams. Tier 4 services were most likely to be using HoNOSCA (used by 50% of teams) and CGAS (used by 48%), both of which are scored and completed by practitioners (Fig. 6.14).

Fig. 6.14: The outcome measures used by different types of CAMHS teams 2007 (N=1047)



Chapter 7.

Caseload and case characteristics



Introduction

7.1 This chapter summarises information collected on caseload in CAMHS mapping. This includes data on caseload size, the length of time cases have waited to be seen and the length of treatment. Attention is also given to key characteristics of the children and young people making up the caseload. The caseload recorded was that of a sample period only. This was the calendar month of November 2007 for tier 2 and 3 teams and the 6-month period 1st June to 30th November 2007 for tier 4 teams. The chapter is structured as follows:

- National summary and trends
- Waiting times and trends
 - New cases seen
 - Cases waiting and length of wait
 - Length of treatment
- Case characteristics and trends
 - Age and gender
 - Ethnicity
 - Primary presentation
 - Referral source.

7.2 Detailed tables of the data used in the following chapter can be found in the CAMHS topic report section of the website at: www.childrensmapping.org.uk/reports.

National summary and trends

Definitions for caseload

Cases: A 'case' is a child, or a young person, or a child / young person and their family, for which a referral has been received and with whom CAMHS staff have actively been working. Where separate referrals were received for one or more siblings in a family, each sibling was counted as a separate case.

Active work: Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion.

Consultation: A consultation requires a specialist CAMHS clinician to provide clinical advice or information for which they can be held accountable. This will usually infer that a record of the consultation will be recorded by at least one party.

Data collection period:

Tier 2/3 teams: caseload data were collected from the 1st to 30th November 2007.

Tier 4 teams: caseload data were collected for the six-month period 1st June to 30th November 2007.

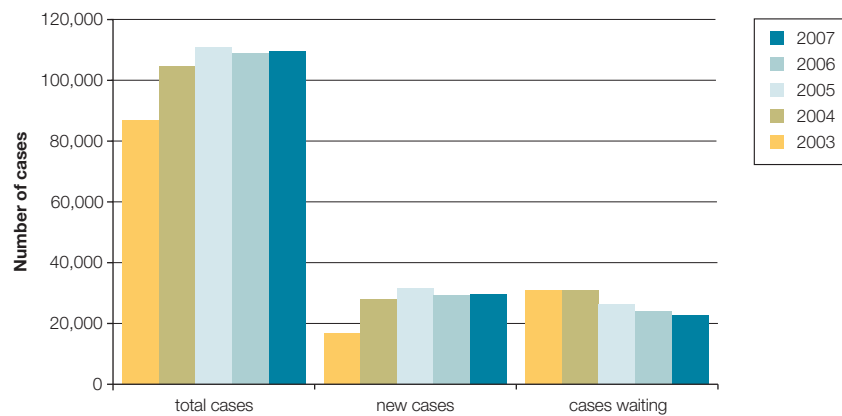
Caseload: The caseload is a count of the total number of cases a team worked with in the data collection period. This is collected at the team level only. If a number of staff within a team work with the same case it should be counted once. The team caseload is effectively a head count of those active cases that have been worked with in the sample period.

Note: a number of services reported having teams with no caseload during the data collection period due to the newness of the team (staff were in post but the team was not yet operational), posts being vacant, staff being on long-term sick/maternity leave or the activities of the team excluded casework.

- 7.3 Caseload is measured using the 'active' caseload for a sample period. An active case was a child or young person (and/or their family) who was seen by a member of staff of a CAMHS team for the purposes of assessment, treatment, monitoring, support or advice/health promotion.
- 7.4 CAMHS professionals may also be consulted about children and young people outside of their service. An important role for tier 2-4 CAMHS teams is to provide specialist advice for staff working within other CAMHS or in less specialised services. Consultations have been recorded separately from the active team caseload since 2006 but trends in caseload size should be read with caution for the following reasons:
- Post 2006 data cannot be compared directly with pre-2005 trends
 - Although 2005 and earlier data should have included consultations – this was clarified in guidance and was the advice of the Helpdesk - analysis of the 2006 data revealed that not all organisations did include them and those that did tended to report lower numbers in a combined figure than they did when they were separately reported in 2006.
 - In 2006, a high number of consultations were reported, but this seems to have been due in part to the question on consultation being new and interpreted in different ways around the country.
- 7.5 It should also be noted that team caseload and consultations are simply a headcount of children and young people who received support, treatment and care from specialist CAMHS professionals or were the subject of specialist advice. They do not reflect either the number of staff who had been involved in the case/intervention, or the intensity of the care provided.
- 7.6 A total of 109,131 active cases were recorded for the 2007 sample period. In addition, CAMHS staff

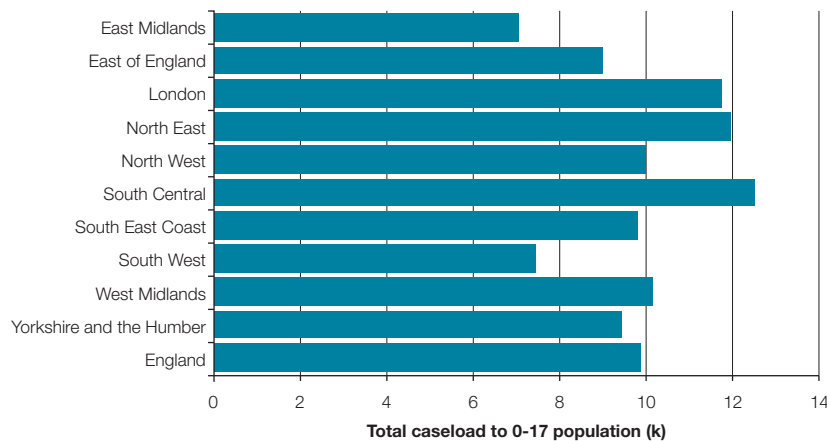
carried out 50,596 consultations giving a total of 159,727 cases seen or consulted on. This was a slight increase on the 108,825 active cases seen in 2006 and 16% reduction on the 60,416 consultations recorded. The 2006 total number of consultation cases was 169,241 (Figs. 7.1).

Fig. 7.1: Trends in cases seen, new cases and cases waiting (excluding consultations) 2003 to 2007



7.7 Examined against the population of 0-17 year olds, the rate of cases per thousand population receiving care nationally was 9.9. This varied between SHAs ranging from 7.0 to 12.5 (Fig. 7.2).

Fig. 7.2: CAMHS caseload by 1k population aged 0 to 17 by SHA: 2007



New cases, waiting times and trends

New cases seen

New cases: A new case was an active case that had been seen for the first time during the data collection period.

Length of Wait: Duration of wait is the interval between the receipt of the referral request and the time the case is first seen. In the case of DNAs or cancellations, the wait is recorded from the most recent DNA or cancellation.

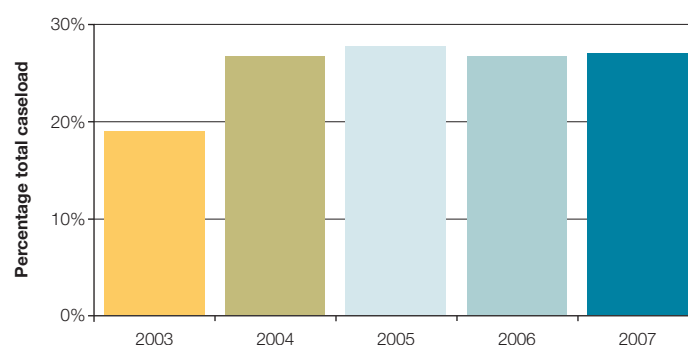
- 7.8 In total there were 29,518 new cases in 2007, a 2% increase on the 29,170 new cases reported in the 2006 exercise. In 2006 there had been a 7% decline on the 31,279 new cases reported in 2005. 2006 is the only year that there was a reported fall in the number of new cases seen in the sample period. It is likely that the separation of consultation from the active caseload question has led to this reduction although this was also the year which saw a slight drop in funding overall for CAMHS. Since 2006 consultations have not been included in the count of any of the follow up questions in the mapping on caseload characteristics. Whilst the definition for a new case should always have excluded consultations, it is possible that a small proportion of consultations were reported as new cases prior to the change in the collection method. Despite the increase in new cases seen in the sample period of the 2006 and 2007 collections, 2005 remains the peak year for the number of new cases. However, in the 5-year period 2003 to 2007, an overall growth of 80% in new cases was reported with 13,156 more new cases reported in 2007 than the 16,362 new cases reported in 2003 sample period (Table 7.1).

Table 7.1: Number of new cases: 2003 to 2007

	New cases	% change on previous year
2003	16362	N/A
2004	27892	70%
2005	31330	12%
2006	29078	-7%
2007	29518	2%

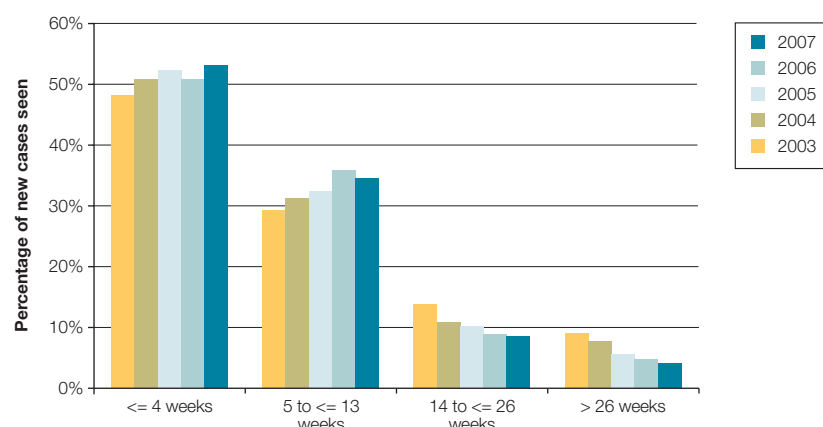
- 7.9 Taken as a proportion of total recorded caseload, cases identified as being 'new' increased from 19% in 2003, to 27% in 2004, 28% in 2005 and fell slightly to 27% in both 2006 and 2007 (Fig. 7.3).

Fig. 7.3: New cases as a proportion of the total caseload: 2003 to 2007



7.10 The majority of new cases (53%) were reported as having waited less than 4 weeks to be seen by a CAMHS team. The wait of 4 weeks or less in the 2006, 2005, 2004 and 2003 mapping was experienced by 51%, 52%, 51% and 48% of new cases respectively. 47% of new cases waited for more than 4 weeks in 2007, this was a lower proportion than in previous years; 49% in 2006, 48% in 2005, 49% in 2004 and 52% in 2003. Waits over 6 months continued to fall. They made up 4% in 2007, falling from 5% in 2006 and 2005, 8% in 2004 and 9% in 2003 (Fig. 7.4).

Fig. 7.4: Length of wait for new cases seen 2003 to 2007



7.11 One of the recommendations of the 2008 CAMHS review was that, "It is important to improve the quality of CAMHS experienced by children, young people and families by reducing waiting times from referral to treatment. The Government should set clear expectations around good practice in this area, and specifically promote approaches that have worked well in reducing waiting times for other services" (Children and young people in mind: the final report of the National CAMHS Review, 2008). The continuing trend of increases in the numbers of children and young people waiting less than 4 weeks with a reduction on the numbers waiting over 14 and 26 weeks suggests that locally services are addressing this issue and in fact 62% of CAMHS teams had no cases waiting over 13 weeks. It is worth noting that this reduction has taken place whilst the number of new cases seen during this period rose by 80%.

Cases waiting and length of wait

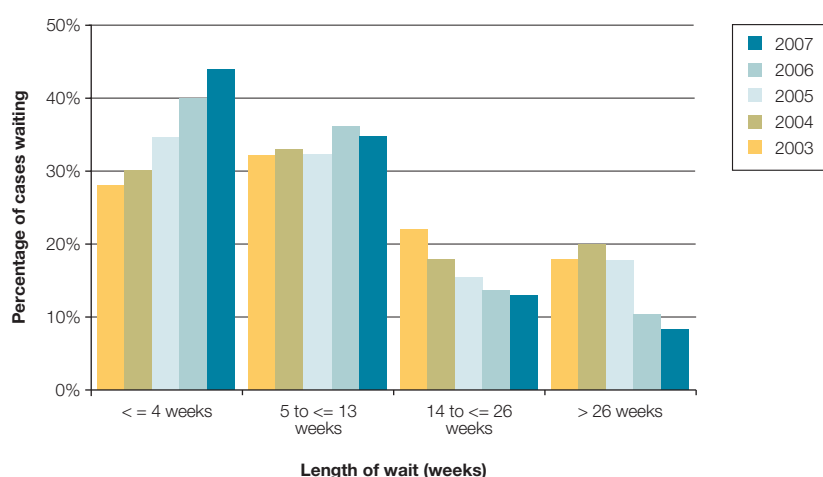
7.12 The number of cases waiting to be seen by CAMHS at the end of the sample period has fallen since 2004 with a reduction of 5% in 2007, 10% in 2006 and 15% in 2005. There were 22,592 cases waiting in 2007 and 30,683 in 2003 (Table 7.2).

Table 7.2: Changes in the number of cases still waiting to be seen at the end of the sample period 2003 to 2007

	Case waiting	% change on previous year
2003	30683	N/A
2004	30660	0%
2005	26207	-15%
2006	23680	-10%
2007	22592	-5%

7.13 The proportion of children and young people still waiting to be seen at the end of the sample period who had been waiting for 4 weeks or less continued to increase from 28% in 2003 to 29% in 2004, 35% in 2005, 40% in 2006 and 44% in 2007. The proportion of cases waiting over 26 weeks fell from 20% in 2004 to 18% in 2005, 10% in 2006 and 8% in 2007 (Fig. 7.5).

Fig. 7.5: Length of wait for cases waiting to be seen at the end of the sample period 2003 to 2007

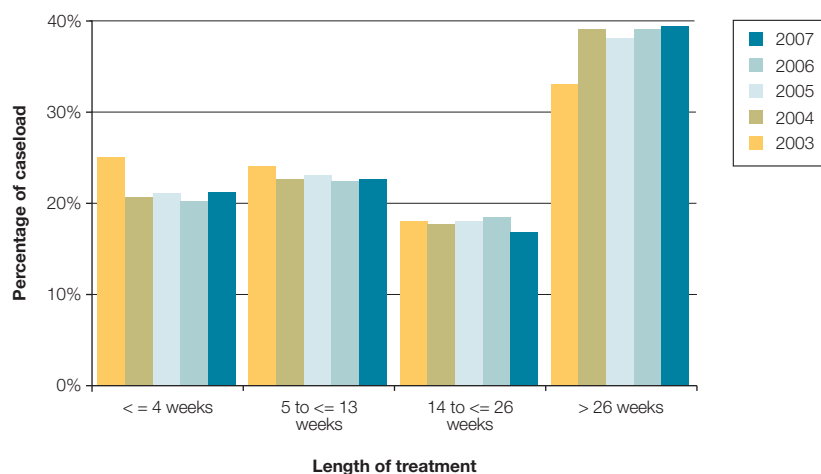


Length of treatment

7.14 The length of treatment measures how long a case had been seen for, or, if the case was closed in the sample period, how long that case had been active. This was reported from the date the case was first worked with up until 30th November 2007, or, if the case was closed in the sample period, until the case was closed. Information on the length of treatment was reported for 106,931 cases overall, 98% of the reported active total caseload.

- 7.15 There were no major changes in the length of treatment. In 2007 cases treated for 4 weeks or less accounted for 21% of the total caseload, a further 23% of the caseload had been treated for between 5 and 13 weeks, 17% 14 to 26 weeks and 29% of the caseload had been treated for over 26 weeks (Fig. 7.6).

Fig. 7.6: Length of treatment 2003 to 2007

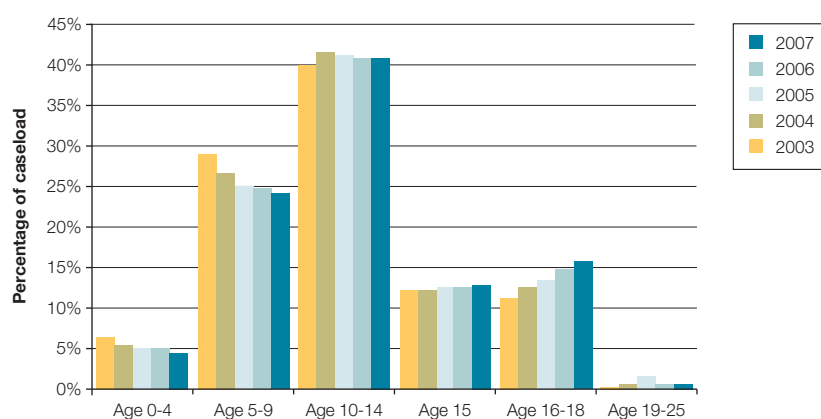


Case characteristics and trends

Age and Gender Profile

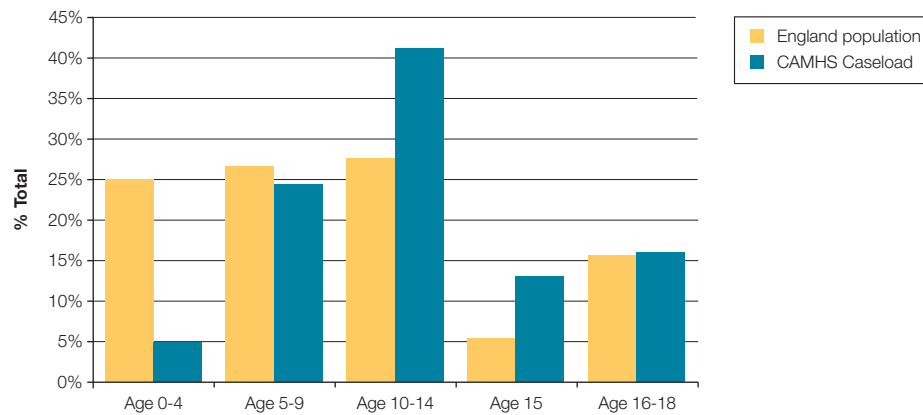
- 7.16 The age profile of children and young people using CAMHS teams has remained relatively static on the whole. Children aged 5 to 9 years old have reduced from 29% of the caseload in 2003 to 24% in 2007 (Fig. 7.7). 10 to 14 year olds have continued to account for between 40% and 42% of the caseload. At the same time the proportion of young people aged 16 to 18 has increased from 11% in 2003 to 16% in 2007.

Fig. 7.7: Age profile of caseload: 2003 to 2007



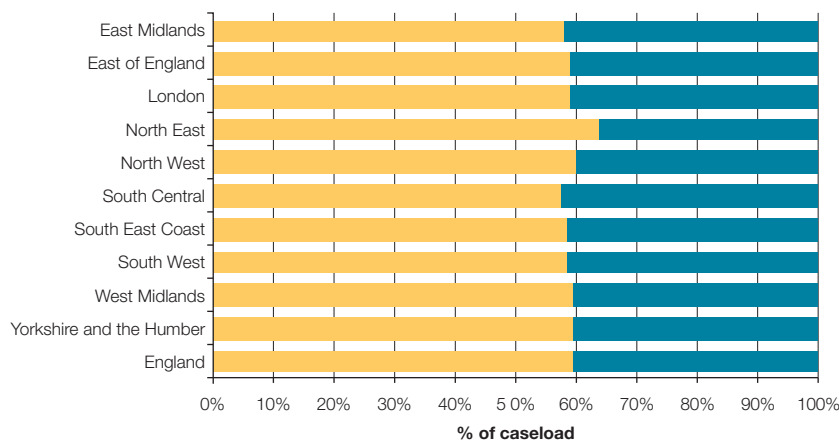
- 7.17 When compared to the age profile of the child population of England, the profile of the CAMHS caseload shows most variance around the very young and 10 to 15 year olds (Fig. 7.8).

Fig. 7.8: Age profile of the England population compared to the CAMHS caseload 2007



7.18 A total of 63,851 cases (59%) were identified as male, and 43,935 cases (41%) were identified as female, the same proportions as in the previous two years. The gender profile by SHA was also remarkably consistent nationally (Fig. 7.9).

Fig. 7.9: Gender of CAMHS caseload by SHA 2007



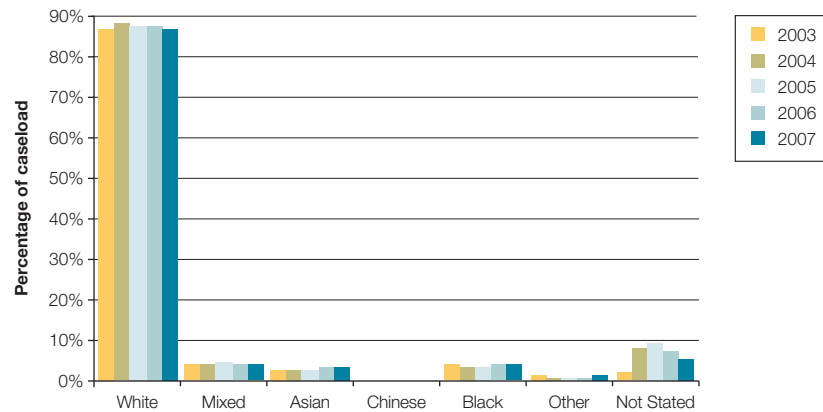
Ethnicity

7.19 The ethnic profile of the children and young people using CAMH services has changed very little in the last 5 years. The most significant change was an increase in the number of cases with no ethnicity indicated. This rose from 2% in 2003 to 8% in 2004 and 10% in 2005, but has gradually begun to fall again to 7% in 2006 and 5% in 2007. The main cause of this change was the inclusion of consultation cases for which full details of case characteristics were not always recorded by the professional being consulted as files on the case might not be held by that team. Since 2006, no case characteristics were expected to be recorded on consultation cases and the reporting of ethnicity has improved (Fig 7.10).

7.20 Excluding cases where ethnicity was not stated, 87% of cases were white, the same proportion as in 2006, but slightly lower than the 88% reported in 2004 and 2005. Cases from a mixed race accounted for 4% of the caseload in 2007 and in every other year since 2003, with the exception of 2005 (5%). Cases from

Asian and Asian British communities accounted for 3% of the total caseload in 2007, and in all previous years going back to 2003, and cases from black and black British communities accounted for 4% of the total caseload in 2007, and in all previous years going back to 2003 (Fig. 7.10).

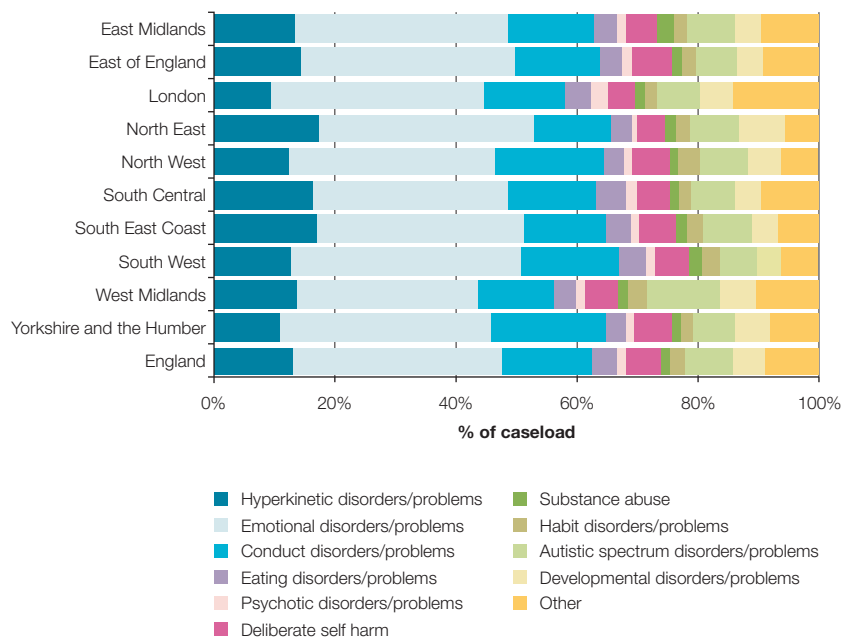
Fig. 7.10: Ethnicity of CAMHS caseload: 2003 to 2007



Primary Presentation

7.21 The primary presentation of children and young people using CAMHS services has changed very little over the last 3 years. Emotional disorders accounted for 34% of caseload. Conduct disorder (15%) and hyperkinetic disorder (13%) remained the next most common reasons for referral to CAMHS. There is some variation in primary presentation by SHA area (Fig. 7.11).

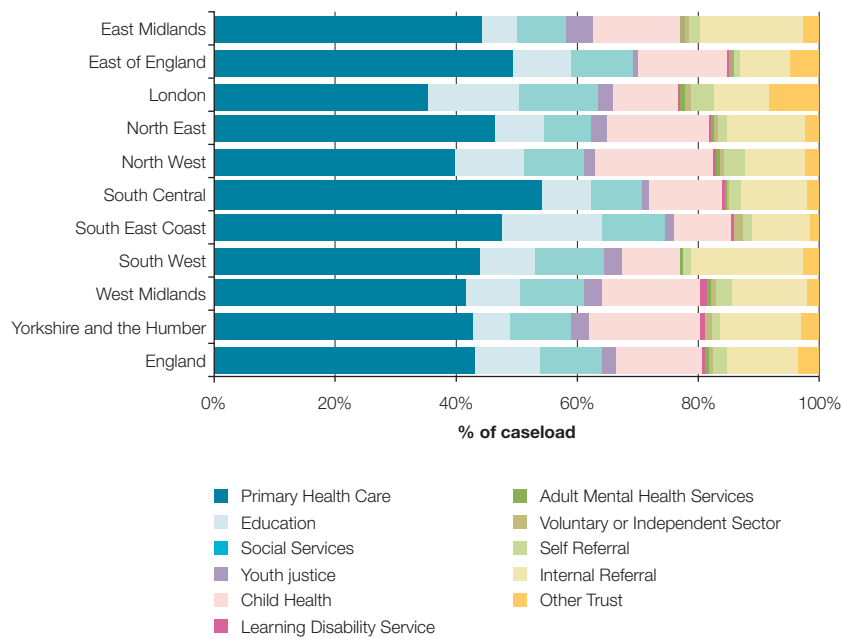
Fig. 7.11: Primary presentation of the CAMHS caseload by SHA: 2007



Referral source

7.22 The largest referral source was from primary health care (44%). A further 14% of referrals came from child health services. 12% of referrals came from within CAMHS, whilst 11% of cases came from education and 10% from social services. There was again some variation by SHA area (Fig. 7.12).

Fig. 7.12: Referral source of service users of CAMHS by SHA: 2007



Appendix 1:

Completion rates 2006 and 2007

A1.1 Completion rates

Child health, CAMHS and maternity services mapping (referred to below as child health mapping) is a voluntary data collection exercise in which all PCTs and NHS child health, CAMHS and maternity services providers are invited to participate. Overall, a very high participation rate is achieved but response rates vary each year both in the number of agencies entering data and the completeness of the data reported.

There are 3 measures which indicate the completeness of data entry:

1. rate of registration on the mapping website
2. rate of sign-off by the Chief Executive Officer of NHS trusts and Directors of Children's Services (DCS) in local authorities to confirm agreement with the data reported
3. rate of sign-off of each individual service questionnaire and finance spreadsheet to confirm that it is complete.

Rates of response against each of these measures are given below for the 2006 and 2007 mapping exercises. No completion rates have been given for 2005 as that was the first year of the exercise for child health and maternity services and before PCT reorganisation.

A1.2 Completion rate 1: Registration rate

Registration indicates that the organisation has knowledge of the exercise, has nominated a Mapping Lead who has accessed the website, completed the registration process and received a password enabling them to enter and revise data. The rates of completion are shown in Table 1.

Table 1: Rates of registration for the mapping exercise 2006 and 2007

	2006			2007		
	Total in England	Number registered	Registration rate	Total in England	Number registered	Registration rate
PCTs	152	152	100%	152	152	100%
NHS Provider Trusts	211	210	99.5%	213	209	99.5%
LAs	150	150	100%	150	150	100%
Total	513	510	99.8%	515	514	99.8%

A1.3 Completion rate 2: CEO/DCS sign off rate

Every year, Chief Executive Officers (CEO) of NHS trusts and Directors of Children's Services (DCS) in local authorities are asked to 'sign off' the mapping data that is being reported by their agency. This signifies that the CEO/DCS has been presented with a report of the data (set up on the mapping website for this purpose) and confirms the data as a description of the organisation's relevant service provision and investment. Separate sign off reports are prepared for finance, child health and maternity services provision, CAMHS provision and performance indicators. The rates of sign-off in 2006 and 2007 are shown in Table 2.

Table 2: Rates of sign off by CEO and DCS 2006 and 2007

	2006			2007		
	Number of agencies registered	Number signed off	Sign off rate	Number of agencies registered	Number signed off	Sign off rate
PCT finance data	152	132	87%	152	144	95%
Child health and maternity service data	316	267	84%	316	292	96%
CAMHS data	110	95	86%	110	101	92%
LA PAF 70 proxy indicator	150	107	71%	150	106	71%
LAs - CAMHS finance	150	114	76%	150	115	77%

A1.4 Completion rate 3a and b: Questionnaires and spreadsheets confirmed complete

At the end of each service questionnaire and finance spreadsheet, data inputters are asked to tick a box to indicate completion of data inputting. As service data is migrated from one year to the next to avoid the need for repeat data entry, this confirmation gives confidence that the data has been reviewed in the current year. Rates of finance spreadsheet sign-off are given in Table 3a. In Table 3b, rates of service questionnaire sign-off are presented for each of the service types mapped.

Table 3a: Rates of sign-off of finance spreadsheets by PCT and LA 2006 and 2007

	2006			2007		
	Number spreadsheets completed	Spreadsheets confirmed complete	% confirmation rate	Number spreadsheets completed	Spreadsheets confirmed complete	% confirmation rate
PCT	1639	1575	96%	1888	1786	95%
LA	212	186	88%	233	217	93%
Total	1851	1761	95%	2121	2003	94%

Table 3b: Rates of sign-off of service questionnaires by service type 2006 and 2007

Service Type	2006			2007		
	Number services mapped	Services confirmed complete	% confirmation rate	Number services mapped	Services confirmed complete	% confirmation rate
School health service	334	294	88%	295	276	94%
Early years and health visiting service	477	415	87%	427	407	95%
Children's therapy service	488	452	93%	494	468	95%
Disabled children's services	391	354	91%	396	366	92%
Safeguarding children service	303	278	92%	277	254	92%
Services for children in special circumstances	282	257	91%	265	245	92%
Tier 1 CAMHS	58	47	81%	42	40	95%
Community paediatrics	466	426	91%	394	360	91%
Children's surgery	213	185	87%	203	191	94%
Specialist paediatric service	188	150	80%	177	170	96%
Paediatric intensive care unit	33	26	79%	29	27	93%
General paediatrics	246	224	91%	242	231	95%
Paediatric emergency service	169	153	91%	169	161	95%
NICU and SCBU	163	146	90%	166	157	95%
Maternity service	194	170	88%	190	181	95%
CAMHS Team	1055	1011	96%	1047	973	93%
Total	5060	4588	91%	4813	4507	94%

Appendix 2:

Working definition of CAMHS tiered system provision

Mental health services for children and adolescents have been described according to a four-tier framework.

Tier 1

The phrase primary care is used to describe agencies that offer first-line services to the public and with whom they make direct contact. This includes interventions by:

- GPs
- Health visitors
- Residential social workers
- Juvenile justice workers
- School nurses
- Teachers
- Family aides, carers and support workers offer various types of assistance that help to prevent family breakdown.

All of these primary care workers regularly encounter early manifestations of difficulty, problems and disorder in children. Complex and serious problems require immediate referral to tier 2 or 3 (specialist) level of CAMHS. The bulk of more minor problems are, and should be, handled within the primary care sector through discussion and counselling.

Role of **Primary Mental Health Workers (PMHWs)**: PMHWs are tasked with supporting and enabling tier 1 professionals and improving the links between the primary and specialist tiers of service. These professionals would need to be integrated into a specialist community CAMHS.

The roles of PMHWs include:

- identifying mental health problems early in their development – early intervention
- offering general advice – and, in certain cases, treatment for less severe mental health problems
- pursuing opportunities for promoting mental health and preventing mental health problems.

Tier 2

A level of service provided by professionals working on their own who relate to others through a network rather than within a team:

- Clinical child psychologists
- Educational psychologists
- Paediatricians – especially community
- Community child psychiatric nurses or nurse specialists
- Child psychiatrists.

Tier 2 services offer:

- training and consultation to other professionals (who might be within tier 1)
- consultation for professionals and families
- outreach to identify severe or complex needs where children or families are unwilling to use specialist services
- assessment which may trigger treatment at this level or in a different tier.

The purpose of tier 2 services is to:

- enable families to function in a less distressed manner,
- enable children and young people to overcome their mental health problems,
- diagnose and treat disorders of mental health,
- enable children and young people to benefit from their home, community and education,
- enable children, young people and their families to cope more effectively with their life experiences.

Tier 3

A specialist service for the more severe, complex and persistent disorders. Because of the complexity of the work that they undertake, staff usually work in a multidisciplinary team or service working in a community child mental health clinic or child psychiatry outpatient service. Tier 3 services might have input from the following professionals:

- Social workers
- Clinical psychologists
- Systematic family therapists
- Community psychiatric nurses
- Child and adolescent psychiatrists
- Art, music and drama therapists
- Child psychotherapists
- Occupational therapists.

In addition to those of tier 2, the tasks of tier 3 services are:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in tier 2 because of the complexity, risk, persistence and interference with social functioning and normal development, and the consequent need for specialist skills.
- To act as gatekeepers, with clearly agreed criteria, for the assessment for referrals to tier 4.
- To have relationships which ease the passage of children and young people into such care
- To contribute to the services, consultation and training at tiers 1 and 2
- To ensure smooth transition of individual cases or families to tiers 2 and 1 before completion of the involvement of tier 3 service
- To participate in research and development projects.

Tier 4

Tier 4 should be seen as part of a continuum of care for clients and families. They are essentially tertiary services such as day units, highly specialised outpatient teams, and inpatient units for older children and adolescents who are severely mentally ill or at suicidal risk.

Tasks undertaken in tier 4 involve:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in tier 3 because of their complexity, risk, persistence and interference with social functioning and normal development, consequently requiring very specialised skills.
- Provision of interventions that require such a level of skill.
- Provision of services that would not be cost effective in every locality because of sporadic demands for them in smaller populations.
- Provision of support to staff working in tiers 1, 2 and 3, where they are engaged in complex cases that might otherwise require management in tier 4.

Sources:

Health Advisory Service (1995) Together we stand. London: HMSO

Audit Commission (1999) Children in Mind. London: Audit Commission.

Appendix 3:

CAMHS technical notes

A3.1: Changes introduced in 2007

- CAMHS commissioners were asked to distinguish between expenditure on tier 2/3 CAMHS and tier 4 services
- The integration of the programming of CAMHS, child health and maternity services mapping was completed with the result that:
 - The questions on ECM outcomes, targeted provision, service user involvement in services and the collection of feedback were asked of CAMHS as well as child health and maternity services
 - A single staff list was used merging CAMHS staff types with child health and maternity staff categories
 - Workforce grades were removed to bring CAMHS data in line with all child health data.

A3.2 Changes introduced in 2006

- CAMHS mapping was moved to the child health mapping website and a single process of registration was introduced for PCTs and other NHS trusts
- Workforce grades were reintroduced to reflect the implementation of Agenda for Change
- A clear separation was introduced to distinguish the active caseload from consultations in team activity. There would be no expectation that clinicians collected full details of the child or young person consulted about during the caseload data collection periods
- New questions were introduced to explore which teams delivered assessments, consultation and liaison, training and particular interventions
- Teams were asked if they used outcome measures and, if so, which ones
- No data was required by the Healthcare Commission for performance purposes but the mapping continued to collect data for the PAF A70 indicator for Ofsted.

A3.3 Changes introduced in 2005

- Workforce grades were removed until the full implementation of Agenda for Change was complete
- The facility for commissioners to register on the mapping website independently was introduced. A specific log in was set up for each commissioning organisation
- Guidance was strengthened around the inclusion of consultation numbers within caseload data
- New local authority questions were introduced linked to performance indicators carried out by the Commission for Social Care Inspection.

A3.4 Changes introduced in 2004

- Individual staff questionnaires dropped
- Commissioners reported and signed-off investment data directly but were contacted initially by service providers
- Previous year's data presented as a starting point
- Caseload data was collected for teams not individual staff
- A new question was introduced to clarify whether teams being mapped for the first time were new investment or just previously unmapped.

A3.5 Checks and reliability

- Summary reports automatically screen data for completeness and plausibility
- Standardised codes and selection from pre-defined lists wherever possible
- Summaries giving overall view of the data entered are signed off by chief executive officers
- Data scrutinised by Durham team during preparation of atlas and performance indicator tables; problems checked with local contacts.

References

- ¹ Health Advisory Service (1995) *Together we stand*. London: The Stationery Office.
- ² Audit Commission (1999) *Children in Mind*. London: Audit Commission.
- ³ National CAMHS Review (2008) *Children and young people in mind: the final report of the National CAMHS Review*.
- ⁴ As above.
- ⁵ Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health/Department for Education and Skills.
- ⁶ Department for Education and Skills (2004) *Every Child Matters*. London: DfES.
- ⁷ Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health/Department for Education and Skills. Standard 9.
- ⁸ Department of Health (2004) *Mental health and psychological well-being of children and young people. National service framework for children, young people and maternity services*. London: Department of Health/Department for Education and Skills. Standard 9 p18.
- ⁹ As above Standard 9 p21.
- ¹⁰ As above Standard 9 p23.

Metadata

Coverage.Spatial	England
Coverage.Temporal	Start date of capture: 2007-11-01 End date of capture: 2008-02-28
Creator	Durham University, School of Applied Social Sciences, help@childrensmapping.org.uk
Date.Issued	June 2009
Date.UpdatingFrequency	Annually
Description	Report of the 2007 child and adolescent health service mapping exercise in England
Format	Text
Identifier	ISBN 978-0-903593-32-8
Language	ISO 639-2 eng
Publisher	Durham University Mapping Team, School of Applied Social Sciences, Durham University, Elvet Riverside II, New Elvet, Durham, DH1 3JT, 0191 334 1489, www.childrensmapping.org.uk , help@childrensmapping.org.uk
Relation.isFormatOf	http://www.childrensmapping.org.uk
Rights.copyright	© Durham University, Durham University Mapping Team, 2009
Status	Version 1.0
Subject	Child and adolescent mental health services
Subject.Category	Mental Health, children's health provision
Title	A Profile of Child and Adolescent Mental Health Services in England 2007/8

Acknowledgements

We would like to thank everybody who has contributed to this child health, CAMHS and maternity services mapping exercise. We thank:

- our senior sponsors for their support which has extended well beyond funding
- our expert advisors and national policy leads for their guidance on the design of the exercise, its interpretation and how it should be reported
- the practitioners and managers who have participated in the exercise for their time and hard work in collecting the data
- Bob Foster, Claire Thomson and Pauline Dowson in the National Mapping Team for their vision, drive and commitment.

Without your help we would not have been able to develop the mapping into a resource that is increasing understanding of service provision and supporting work to improve outcomes for children and young people.



We would also make a special mention and thanks to Simon, Lee, Ruth, Charlotte, Kirsty, Rebecca, Dale, Coleen and Jonathan for the artwork that has become the trademark for CAMHS mapping. They originally developed the work in 2002 with the support of 'Investing in Children' when they were aged 8 to 11 years old. The children were from Easington, Derwentside, Durham and Chester-le-Street in County Durham. They made the figures while working in a group facilitated by Tees, Esk and Wear Valleys NHS Trust. The aim of the group was to promote self-esteem through art and story telling. The figures were made of collage and were life-sized.

ISBN 978-0-903593-32-8

School of Applied Social Sciences
Durham University
Elvet Riverside 2
New Elvet
Durham
DH1 3JT

email: help@childrensmapping.org.uk

web: www.childrensmapping.org.uk/reports

June 2009

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designed@belongcreative.co.uk

belong
creative